

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery						MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia						b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN lb 26 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington													
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.						d. STREET ADDRESS 1621 Otis Street, N.E.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)						First Middle Last Elijah Henry Allen, Jr.						4. DATE OF DEATH Month Day Year September 20 1960													
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 10, 1903		9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician						10b. KIND OF BUSINESS OR INDUSTRY Medical						11. BIRTHPLACE (State or foreign country) Washington, D.C.						12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Elijah H. Allen, Sr.						14. MOTHER'S MAIDEN NAME Emma Russell																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. None						17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland													
MEDICAL CERTIFICATION												18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage from Esophageal Varices days 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. } (b) Thrombosis of Portal Vein weeks DUE TO (c) Post Necrotic Cirrhosis months													
												PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
												20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
												20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from August 25, 1960, to September 20, 1960, that (I) (we) lost saw the deceased alive on September 20, 1960, and that death occurred at 8:00 PM from the causes and on the date stated above.												22a. SIGNATURE Robert R. Carpenter MD M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 9/21/60													
22c. PHYSICIAN'S NAME (Type) Robert R. Carpenter, M. D.						22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.																			
23a. BURIAL, CREMATION, REMOVAL (Specify) 9/24/60				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery				23d. LOCATION (City, town, or county) (State) Suitland, (Suitland) Maryland													
24. FUNERAL DIRECTOR'S SIGNATURE John T. Ruane						ADDRESS 3015 - 12th St., N.E. Washington 17, D.C.						25a. REC'D BY REGISTRAR SEP 26 '60		25b. REGISTRAR'S SIGNATURE Curtis & Evans											

1. The first step is to identify the key components of the system. This involves understanding the hardware, software, and data involved in the process.

10412

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10369

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM & HOSPITAL</u>				d. STREET ADDRESS <u>14 Sherman Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Hugo</u> Middle <u>Faust</u> Last <u>Ambrosi</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-93</u>		9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Examiner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Faust A. Ambrosi</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Lombardi</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 <u>with 3rd degree Pap. Circumang. Blockade</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>surgery</u> (b) <u>with 3rd degree Pap. Circumang. Blockade</u> (c) <u>surgery</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/11/39</u> to <u>9/29/60</u> , that (I) (we) last saw the deceased alive on <u>9/29/60</u> , and that death occurred at <u>11:25</u> P. M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Howard T. Morse</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD T. MORSE</u>				22d. ADDRESS <u>7030 Carroll Ave. Takoma Park Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 3, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Balton Hgts., Harpers Ferry W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll St NW. D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 3 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur J. Walters</u>			

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Name of physician: [illegible]
6. Name of funeral home: [illegible]
7. Name of next of kin: [illegible]
8. Name of informant: [illegible]
9. Signature of informant: [illegible]
10. Date of report: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSMC
SM 7/59

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FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10460 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10370									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Monrovia d. STREET ADDRESS Rt. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Walter Edward Anderson					4. DATE OF DEATH September 4 19 60				
5. SEX male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1895		9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deliveryman			10b. KIND OF BUSINESS OR INDUSTRY Ice			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Anderson					14. MOTHER'S MAIDEN NAME Bessie Washington				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) W.W. # 1			16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____								INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> 9-4-60 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED									
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type) Frank J. Broschart M.D.			Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/6/60		22c. NAME OF CEMETERY OR CREMATORY Pleasant Grove			22d. LOCATION (City, town, or country) (State) Purdum, Md.		
23. FUNERAL DIRECTOR Olin L. W. Johnson ADDRESS Damascus, Md.			24a. REC'D BY REGISTRAR SEP 7 '60 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus				

10-10 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10371

10389

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN TB 5 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8915 GEORGIA AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 29 SILVER SPRING d. STREET ADDRESS 1 8915 GEORGIA AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle KATHERINE Last ARENDS		4. DATE OF DEATH Month SEPTEMBER Day 29 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/22/82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) SALEM, MICHIGAN
13. FATHER'S NAME GEORGE STAEB		14. MOTHER'S MAIDEN NAME KATHERINE FINKBINER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Dr. Theodore G. Arends, 8915 Ga. Ave. Silver Spring, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) sudden DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of previous heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE (AS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 9/29/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/1/60	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY
23. FUNERAL DIRECTOR Warner E. Pimphrey, Inc.		22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND	
24a. REC'D BY REGISTRAR OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the registrar. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 10372

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> , MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6907 Maple Ave., Chevy Chase, Md.</u>		d. STREET ADDRESS <u>6907 Maple Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>H.</u> Last <u>Barnard</u>		4. DATE OF DEATH Month <u>September</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/02</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elect. Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bureau of Standards Wash., D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Montgomery Barnard</u>		14. MOTHER'S MAIDEN NAME <u>Grace Haliday</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>467-03-8795</u>	
17. INFORMANT <u>Dorothy W. Barnard-Item # 2</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous coronary disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u> </u>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		DATE SIGNED <u>9/29/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>1331 E. Montgomery Ave. Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Code 101

1. NAME

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE

11. DATE

12. TIME

13. PLACE

14. SIGNATURE

15. DATE

16. TIME

17. PLACE

18. SIGNATURE

19. DATE

20. TIME

21. PLACE

22. SIGNATURE

23. DATE

24. TIME

25. PLACE

26. SIGNATURE

27. DATE

28. TIME

29. PLACE

30. SIGNATURE

31. DATE

32. TIME

33. PLACE

34. SIGNATURE

35. DATE

36. TIME

37. PLACE

38. SIGNATURE

39. DATE

40. TIME

41. PLACE

42. SIGNATURE

43. DATE

44. TIME

45. PLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10373

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 Hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 17 Pratt Street	
3. NAME OF DECEASED (Type or print) First Ralph Middle Elmer Last Bates		4. DATE OF DEATH Month September Day 15 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1894
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ralph Bates		14. MOTHER'S MAIDEN NAME Ella Morrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic carcinoma with wide spread metastasis DUE TO Severe atherosclerosis of aorta and coronaries with old anterior wall infarct (c) old anterior wall infarct PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 Days 1 Year 1 Year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 15, 1960 to September 15, 1960 , that (I) (we) last saw the deceased alive September 15, 1960 , and that death occurred at 4:12p M, from the causes and on the date stated above.			
22a. SIGNATURE Jerome B. Block		22b. DATE SIGNED September 16, 1960	
22c. PHYSICIAN'S NAME (Type) Jerome B. Block, M.D.		22d. ADDRESS The Clinical Center National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) 9/19/60		23b. DATE THEREOF 9/19/60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City, town, or county) (State) Colmor Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J.Wm. Lee's Sons Co.		25a. REC'D BY REGISTRAR SEP 19 '60	
ADDRESS 300-4th Street N.E.		25b. REGISTRAR'S SIGNATURE Charles E. Kneass	

CERTIFICATE OF DRAFT

10164



UNITED STATES OF AMERICA

Department of the Interior

Division of Reclamation

Washington, D. C.

June 1, 1916

Whereas, the following named persons have been found to be entitled to the benefits of the Reclamation Act of 1902, to-wit:

JOHN A. SMITH, of the State of California

and

JOHN B. SMITH, of the State of California

are hereby certified to be entitled to the benefits of the Reclamation Act of 1902.

Witness my hand and the seal of the Department of the Interior at Washington, D. C., this 1st day of June, 1916.

JOHN A. SMITH, Secretary of the Interior

By _____, Assistant Secretary of the Interior

Division of Reclamation

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10390
CERTIFICATE OF DEATH

10374

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 10 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 SILVER SPRING		d. STREET ADDRESS 1 9506 Ocala Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9506 Ocala Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ELIZABETH Last BEALL		4. DATE OF DEATH Month 9 Day 16 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/76
9. AGE (In years lost birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't. Mgr. Gov't. Cafeteria (retired)		12. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RHYNALDO SNYDER		14. MOTHER'S MAIDEN NAME HARRIETT POOLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-09-7411	
17. INFORMANT Mrs. Thelma B. Matthews, 9506 Ocala St.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Semility INTERVAL BETWEEN ONSET AND DEATH @ 10 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 19 53 to Sept 13 19 60 , that (I) (we) last saw the deceased alive on Sept 13 19 60 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Bernard A. Fitzgerald		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) BERNARD A. FITZGERALD		22d. ADDRESS 217 UNIVERSITY BLVD E., S.S. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/20/60	
23c. NAME OF CEMETERY OR CREMATORY SALEM METH. CHURCH CEMETERY		23d. LOCATION (City, town, or county) (State) CEDAR GROVE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jiska		25a. REC'D BY REGISTRAR DATE SEP 21 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



CHIEF OF BUREAU

10000

CERTIFICATE OF DEATH

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Form with multiple lines for text entry, including fields for name, date, and other details. The text is mostly illegible due to blurriness.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10442

10375

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.			
c. LENGTH OF STAY IN 1b 9 months				d. STREET ADDRESS 10011 Brunett Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last J. Leonard Bean				4. DATE OF DEATH Month Day Year Sept. 11 1960			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/31/1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Gov't		10b. KIND OF BUSINESS OR INDUSTRY Govt.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BenJ. A. Bean		14. MOTHER'S MAIDEN NAME Mary F. Blundon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 1 month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 3 1956 to Sept. 11 1960 that (I) (we) last saw the deceased alive on Sept. 11 1960 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Raymond Bradshaw, Jr. M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/11/60	
22c. PHYSICIAN'S NAME (Type) Raymond Bradshaw, Jr.				22d. ADDRESS 345 University Blvd, West Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/60		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery		23d. LOCATION (City, town, or county) (State) Bethesda, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey ADDRESS Bethesda, Maryland				25a. REC'D BY REGISTRAR SEP 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

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TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10462
CERTIFICATE OF DEATH

10376

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Herndon		Herndon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS Route #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Grace Middle Mae Last BEARD		4. DATE OF DEATH Month Sept. Day 5th Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-86
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Beard		14. MOTHER'S MAIDEN NAME Mary Siebert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert H. Beard CTC USN		18. ADDRESS U.S. Naval Security Station, Wash., D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus (c) Urolithiasis + pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-11 19 60 , that (I) (we) last saw the deceased alive on 9-5 19 60 , and that death occurred at 12:58 AM from the causes and on the date stated above.			
22a. SIGNATURE John H. Mazur LT MC USN		22b. DATE SIGNED 9-5-60	
22c. PHYSICIAN'S NAME (Type) John H. Mazur LT MC USN		22d. ADDRESS U. S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 7-1960	
23c. NAME OF CEMETERY OR CREMATORY Chestnut Grove Cemetery		23d. LOCATION (City, town, or county) (State) Herndon Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Green Funeral Home, Herndon, Virginia		25a. REC'D BY REGISTRAR SEP 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

1945

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10463

CERTIFICATE OF DEATH

Reg. Dist. No.

10377

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4883 Battery Lane, Apt. #1</u>		d. STREET ADDRESS <u>14883 Battery Lane, Apt. #1</u>	
3. NAME OF DECEASED (Type or print) <u>Olga A Benedict</u>		4. DATE OF DEATH <u>Sept 2 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1919</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Beaumont, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alex Angelo</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Kiatka</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Yes unknown</u>	
17. INFORMANT <u>Mr. George Benedict</u>		Address <u>4883 Battery Lane, Apt. #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertension</u> DUE TO (c) <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Sept</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 1</u> , 19 <u>60</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Md</u> DATE SIGNED <u>9/2/60</u>			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.		ADDRESS <u>4890 Battery Lane, Bethesda</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>		DATE <u>9/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-6-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10443

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 15, 1944		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Retired		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. MARITAL STATUS Married		14. DATE OF MARRIAGE 1910		15. NAME OF SPOUSE Mary H. Harris	
16. NAME OF PHYSICIAN Dr. J. H. Smith		17. NAME OF HOSPITAL None		18. NAME OF NURSE None	
19. NAME OF CORONER John A. Brown		20. NAME OF BURIAL PLACE St. Mary's Cemetery		21. NAME OF MINISTER Rev. J. K. Jones	
22. NAME OF FUNERAL HOME None		23. NAME OF CEMETERY St. Mary's Cemetery		24. NAME OF INTERMENT None	
25. NAME OF DECEASED'S FATHER John H. Harris		26. NAME OF DECEASED'S MOTHER Elizabeth H. Harris		27. NAME OF DECEASED'S BIRTH April 15, 1879	
28. NAME OF DECEASED'S BIRTH April 15, 1879		29. NAME OF DECEASED'S BIRTH April 15, 1879		30. NAME OF DECEASED'S BIRTH April 15, 1879	
31. NAME OF DECEASED'S BIRTH April 15, 1879		32. NAME OF DECEASED'S BIRTH April 15, 1879		33. NAME OF DECEASED'S BIRTH April 15, 1879	
34. NAME OF DECEASED'S BIRTH April 15, 1879		35. NAME OF DECEASED'S BIRTH April 15, 1879		36. NAME OF DECEASED'S BIRTH April 15, 1879	
37. NAME OF DECEASED'S BIRTH April 15, 1879		38. NAME OF DECEASED'S BIRTH April 15, 1879		39. NAME OF DECEASED'S BIRTH April 15, 1879	
40. NAME OF DECEASED'S BIRTH April 15, 1879		41. NAME OF DECEASED'S BIRTH April 15, 1879		42. NAME OF DECEASED'S BIRTH April 15, 1879	
43. NAME OF DECEASED'S BIRTH April 15, 1879		44. NAME OF DECEASED'S BIRTH April 15, 1879		45. NAME OF DECEASED'S BIRTH April 15, 1879	
46. NAME OF DECEASED'S BIRTH April 15, 1879		47. NAME OF DECEASED'S BIRTH April 15, 1879		48. NAME OF DECEASED'S BIRTH April 15, 1879	
49. NAME OF DECEASED'S BIRTH April 15, 1879		50. NAME OF DECEASED'S BIRTH April 15, 1879		51. NAME OF DECEASED'S BIRTH April 15, 1879	
52. NAME OF DECEASED'S BIRTH April 15, 1879		53. NAME OF DECEASED'S BIRTH April 15, 1879		54. NAME OF DECEASED'S BIRTH April 15, 1879	
55. NAME OF DECEASED'S BIRTH April 15, 1879		56. NAME OF DECEASED'S BIRTH April 15, 1879		57. NAME OF DECEASED'S BIRTH April 15, 1879	
58. NAME OF DECEASED'S BIRTH April 15, 1879		59. NAME OF DECEASED'S BIRTH April 15, 1879		60. NAME OF DECEASED'S BIRTH April 15, 1879	
61. NAME OF DECEASED'S BIRTH April 15, 1879		62. NAME OF DECEASED'S BIRTH April 15, 1879		63. NAME OF DECEASED'S BIRTH April 15, 1879	
64. NAME OF DECEASED'S BIRTH April 15, 1879		65. NAME OF DECEASED'S BIRTH April 15, 1879		66. NAME OF DECEASED'S BIRTH April 15, 1879	
67. NAME OF DECEASED'S BIRTH April 15, 1879		68. NAME OF DECEASED'S BIRTH April 15, 1879		69. NAME OF DECEASED'S BIRTH April 15, 1879	
70. NAME OF DECEASED'S BIRTH April 15, 1879		71. NAME OF DECEASED'S BIRTH April 15, 1879		72. NAME OF DECEASED'S BIRTH April 15, 1879	
73. NAME OF DECEASED'S BIRTH April 15, 1879		74. NAME OF DECEASED'S BIRTH April 15, 1879		75. NAME OF DECEASED'S BIRTH April 15, 1879	
76. NAME OF DECEASED'S BIRTH April 15, 1879		77. NAME OF DECEASED'S BIRTH April 15, 1879		78. NAME OF DECEASED'S BIRTH April 15, 1879	
79. NAME OF DECEASED'S BIRTH April 15, 1879		80. NAME OF DECEASED'S BIRTH April 15, 1879		81. NAME OF DECEASED'S BIRTH April 15, 1879	
82. NAME OF DECEASED'S BIRTH April 15, 1879		83. NAME OF DECEASED'S BIRTH April 15, 1879		84. NAME OF DECEASED'S BIRTH April 15, 1879	
85. NAME OF DECEASED'S BIRTH April 15, 1879		86. NAME OF DECEASED'S BIRTH April 15, 1879		87. NAME OF DECEASED'S BIRTH April 15, 1879	
88. NAME OF DECEASED'S BIRTH April 15, 1879		89. NAME OF DECEASED'S BIRTH April 15, 1879		90. NAME OF DECEASED'S BIRTH April 15, 1879	
91. NAME OF DECEASED'S BIRTH April 15, 1879		92. NAME OF DECEASED'S BIRTH April 15, 1879		93. NAME OF DECEASED'S BIRTH April 15, 1879	
94. NAME OF DECEASED'S BIRTH April 15, 1879		95. NAME OF DECEASED'S BIRTH April 15, 1879		96. NAME OF DECEASED'S BIRTH April 15, 1879	
97. NAME OF DECEASED'S BIRTH April 15, 1879		98. NAME OF DECEASED'S BIRTH April 15, 1879		99. NAME OF DECEASED'S BIRTH April 15, 1879	
100. NAME OF DECEASED'S BIRTH April 15, 1879		101. NAME OF DECEASED'S BIRTH April 15, 1879		102. NAME OF DECEASED'S BIRTH April 15, 1879	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10433

10378

Items 11, 12 Film 62-72 10-5-60 et

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7107 Pomander Lane		d. STREET ADDRESS 7107 Pomander Lane	
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last BENTZ		4. DATE OF DEATH Month Sept. Day 23, Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1881
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months 8 Days 24 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) England Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Turk		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Husband		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess, chronic abdominal 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of colon DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 19, 1960 to Sept 23, 1960 that (I) (we) last saw the deceased alive on Sept. 19, 1960 and that death occurred at 8:15 AM from the causes and on the date stated above.			
22a. SIGNATURE Thomas A. Wildman		22b. DATE SIGNED 9-23-60	
22c. PHYSICIAN'S NAME (Type) THOMAS A. WILDMAN		22d. ADDRESS 3729 Morrison St. NW, Wash. D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26, 1960	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
25a. REC'D BY REGISTRAR DATE SEP 27 '60		25b. REGISTRAR'S SIGNATURE Carlton S. Hume	



13

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

10443
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10379

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Keensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN TB <u>1 day</u>		d. STREET ADDRESS <u>1371 Locust Rd NW</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10309 Keensington Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mark Hanna Blacker</u>		4. DATE OF DEATH Month Day Year <u>Sept 1 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-10</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.E.</u>	
13. FATHER'S NAME <u>Frank Blacker (DEC.)</u>		14. MOTHER'S MAIDEN NAME <u>Lea Roman (DEC.)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>230-10-9504</u>	
17. INFORMANT <u>Wathan Needle</u>		Address <u>9608 Clearview Pl. Silver Spring, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschett</u>		DATE SIGNED <u>9-1-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschett</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/4/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L MEM PARK</u>		22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Deborah Kuehl Home</u>		24a. REC'D BY REGISTRAR <u>SEP 6 '60</u>	
ADDRESS <u>4217-9th Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH OR 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
MARRIED		SINGLE		WIDOWED		DIVORCED	
RACE		RELIGION		EDUCATION		OCCUPATION	
PLACE OF BIRTH		CITY OF RESIDENCE		STREET ADDRESS		CITY AND STATE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY		PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		LABORATORY DATA	
POST-MORTEM EXAMINATION		AUTOPSY		TOXICOLOGY		BACTERIOLOGY	
PATHOLOGICAL FINDINGS		GROSS FINDINGS		MICROSCOPIC FINDINGS		HISTOCHEMISTRY	
IMPRESSION		CONCLUSIONS		REMARKS		SIGNATURE OF EXAMINER	
DATE OF REPORT		PLACE OF REPORT		CITY AND STATE		COUNTRY	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10380

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN b. 10 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 406 Hinsdale Lane		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 406 Hinsdale Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Earl Blair		4. DATE OF DEATH Month Sept Day 17 , Year 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1900		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Col. USA		10b. KIND OF BUSINESS OR INDUSTRY retired			
11. BIRTHPLACE (State or foreign country) Ark.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Edw. Thomas Blair		14. MOTHER'S MAIDEN NAME Cherry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Virginia Blair (wife)			
17. INFORMANT Item 2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Fracture of Skull (b) DUE TO Coronary occlusion (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 900.0		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down basement steps at home			
20c. TIME OF INJURY Month, Day, Year Hour 6:00 m. 9/17/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) Silver Spring, Montg. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 20 SEPT. 1960			
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or country) (State) ARLINGTON VA.			
23. FUNERAL DIRECTOR Rinaldi Funeral Home		24a. REC'D BY REGISTRAR SEP 22 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. House		DATE SIGNED 9/19/60			

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
10464
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10381

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carmi	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 211 State Street	
3. NAME OF DECEASED (Type or print) First Martha Middle Christine Last Blanton		4. DATE OF DEATH Month September Day 11 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1953
9. AGE (In years lost birthday) 7 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Blanton		14. MOTHER'S MAIDEN NAME Helen Sawyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphatic leukemia DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 13 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 6, 1960 to September 11, 1960 that (I) (we) last saw the deceased alive on September 11, 1960 and that death occurred at 6:15 AM from the causes and on the date stated above.			
22a. SIGNATURE W. Walter Oppelt M.D.		22b. DATE SIGNED 9/11/60	
22c. PHYSICIAN'S NAME (Type) W. WALTER OPPELT, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIR R.R. 9-12-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) CARMI ILL	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. 1400 Chapin St. N.E.		25a. REC'D BY REGISTRAR DATE SEP 19 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

10-1-64

1

The Clinical Center, Department of Health, State of Maryland

On the 1st day of January, 1964, at the age of 65 years

Female, White, born [illegible] January 6, 1899

Residence [illegible] Baltimore, Maryland

Cause of Death [illegible]

On the 1st day of January, 1964, at the age of 65 years

Female, White, born [illegible] January 6, 1899

Residence [illegible] Baltimore, Maryland

Cause of Death [illegible]

On the 1st day of January, 1964, at the age of 65 years

Female, White, born [illegible] January 6, 1899

Residence [illegible] Baltimore, Maryland

Cause of Death [illegible]

On the 1st day of January, 1964, at the age of 65 years

Female, White, born [illegible] January 6, 1899

Residence [illegible] Baltimore, Maryland

Cause of Death [illegible]

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10392

CERTIFICATE OF DEATH

10382

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Charleston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charleston	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2105 Reedy Drive		d. STREET ADDRESS 1510 Dixie Street.	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle H. Last BLOOM		4. DATE OF DEATH Month Sept. Day 4 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 22, 1889
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 4 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer (Ret)		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Roumania		12. CITIZEN OF WHAT COUNTRY? Roumania	
13. FATHER'S NAME Joseph Bloom		14. MOTHER'S MAIDEN NAME Minnie Peck	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-12-5568	
17. INFORMANT Rose M. Bloom		1510 Dixie Street Charleston, West Virginia	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Generalized atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver		INTERVAL BETWEEN ONSET AND DEATH months years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 1960 to Sept 4 1960 that (I) (we) last saw the deceased alive on Aug 1960 and that death occurred at 12:40 PM, from the causes and on the date stated above.			
22a. SIGNATURE Abraham W. Danish		22b. DATE SIGNED 9-4-60	
22c. PHYSICIAN'S NAME (Type) Abraham W. Danish		22d. ADDRESS 927 Pershing Dr., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-1960	
23c. NAME OF CEMETERY OR CREMATORY Mt. Wood Cemetery		23d. LOCATION (City, town, or county) (State) Wheeling, West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Gooding Funeral Home		24b. ADDRESS 4217 9th Street N.W.	
25a. REC'D BY REGISTRAR SEP 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

Residence

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10444
CERTIFICATE OF DEATH

10383

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4400 Glenridge Street		d. STREET ADDRESS 4400 Glenridge St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDNA Middle P. Last BOHRER		4. DATE OF DEATH Month Sept. Day 9, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1890
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 2 Days 17 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.B.X. Operator		10b. KIND OF BUSINESS OR INDUSTRY Apartment Bldg.	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME B. F. Ryan		14. MOTHER'S MAIDEN NAME Maude Henry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. yes	
17. INFORMANT Daughter Address Shirley B. Heflin		Same as #2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) myocardial Infarction. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 4 , 19 60 , to Sept 7 , 19 60 , that (I) (we) last saw the deceased alive on Sept 7 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Robert Kramer		22b. DATE SIGNED 9-10-60	
22c. PHYSICIAN'S NAME (Type) Robert Kramer		22d. ADDRESS 1703 East West Highway SS.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-12-60	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR SEP 14 '60 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10465

10384

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 Months 27 days McLean	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		d. STREET ADDRESS 4314 Oakdale Road	
3. NAME OF DECEASED (Type or print) First Esther Middle Harris Last BOODA		4. DATE OF DEATH Month September Day 15 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-91
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William S. HARRIS		14. MOTHER'S MAIDEN NAME Emma SANDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Larry BOODA, 4314 Oakdale Rd., McLean, Va.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO (b) Anemia DUE TO (c) Generalized Metastatic Adenocarcinoma Endometrium CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 mo 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-19-1960 to 9-15-1960 , that (I) (we) last saw the deceased alive on 9-15-1960 , and that death occurred 12:20 PM from the causes and on the date stated above.			
22a. SIGNATURE R. F. Mading		22b. DATE SIGNED 9-15-60	
22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT JG, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/16/60	
23c. NAME OF CEMETERY OR CREMATORY Paxtang Cemetery		23d. LOCATION (City, town, or county) (State) Harrisburg, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE H. H. Hines		25a. REC'D BY REGISTRAR SEP 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10385

10413

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK MD</u>		c. LENGTH OF STAY IN 1b <u>80 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 TAKOMA PARK</u>		d. STREET ADDRESS <u>17711 GREENWOOD AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>MARIE</u> Last <u>BOWEN</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-96</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>OHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Hood</u>		14. MOTHER'S MAIDEN NAME <u>MARIE HUNT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory embarrassment and hyperpyrexia</u> <u>237x</u> DUE TO <u>BRAIN Stem compression</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to probable brain tumor</u> DUE TO <u>Progressive cerebro-vascular insufficiency</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 to 3 wks.</u> <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 7, 1960</u> to <u>Sept 15, 1960</u> that (I) (we) last saw the deceased alive on <u>9/14</u> 19 <u>60</u> and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John T. Lord</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord and</u>		22d. ADDRESS <u>909 Pershing Dr Silver Sp. Mt</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>Sept-19-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Wheeling - West Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>SEP 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fines</u>		25c. DATE	

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATE OF DEATH

10418

(M)

(1)

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10393

10386

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 13 Mo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home		d. STREET ADDRESS 3335 Quesada St. N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOTTIE Middle E Last Bradford		4. DATE OF DEATH Month September Day 23 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1876
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James O. Carter		14. MOTHER'S MAIDEN NAME Mary McEvoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Thomas A. Bradford-3335 Quesada, St. N. W.		Address Wash. D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Degilitation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Peritonitis DUE TO (c) Diverticulitis, Colon		INTERVAL BETWEEN ONSET AND DEATH 48 hrs 48 hrs 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 1959 to Sep 23 1960 that (I) (we) last saw the deceased alive on Sept 23 1960 , and that death occurred at 10:20pm M, from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Thibadeau M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10:20pm 22b. DATE SIGNED Sept 23, 1960	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		22d. ADDRESS 10609 Concord St., Kensington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 26/1960	
23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		ADDRESS Washington, D. C.	
25a. REC'D BY REGISTRAR SEP 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10394

CERTIFICATE OF DEATH

Reg. Dist. No.

10387

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 11/21/54 - 1/4/60	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cedarcroft Sanitarium & Hospital		d. STREET ADDRESS 1707 Columbia Rd NW	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle M. Last Brinton		4. DATE OF DEATH Month 9- Day 4 Year 1960	
5. SEX M.	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-6-1870
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auditor for Internal Revenue		10b. KIND OF BUSINESS OR INDUSTRY Federal Gov.	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nephew		Address Chevy Chase, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 20, 1958 to 9-4, 1960 , that I last saw the deceased alive on 9-4, 1960 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Aldo Vacca		ADDRESS (Street, city or town, state) 1429 University Blvd, W. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Aldo Vacca		DATE SIGNED 9-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 9/7/60	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 9 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10414

10388

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakons Park</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		d. STREET ADDRESS <u>6923 Maple St. NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Georgetown Rehab. Home</u> <u>7300 Baltimore Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>—</u> Last <u>BRISCOE</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 25, 1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip E. Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Willie Humphries</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Philip E. Briscoe, Jr.</u>		Address <u>7000 Poplar Ave T.P.Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. 19 <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/6</u> 19 <u>56</u> to <u>9/22</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>9/21</u> 19 <u>60</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>A. B. Little</u>		22b. DATE SIGNED <u>9/22/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE</u>		22d. ADDRESS <u>6911 5th St. NW Washington, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 24, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Back Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Hatter</u>		25a. REC'D BY REGISTRAR <u>SEP 26 '60</u>	
ADDRESS <u>251 Carroll St. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>C. L. S. Hines</u>	

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10395

10389

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>9 months</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Silver Spring, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9500 Saginaw Avenue</u>		d. STREET ADDRESS <u>13700 9500 Saginaw Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Virginia</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alfred C. Tolson</u>		14. MOTHER'S MAIDEN NAME <u>Kathrine Elizabeth O'Hare</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (son) <u>John C. Brown</u>		Address <u>Wash, D.C. 7413 Blair Rd. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1</u> 19 <u>60</u> to <u>Sept. 1</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Aug. 26</u> 19 <u>60</u> , and that death occurred at <u>6:15</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles W. Humphreys, Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>9/1/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, Jr.</u>		22d. ADDRESS <u>1746 K St. N.W. Washington D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/3/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jiska</u> ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

10335

CENTRAL DE DEATH

10335

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Handwritten text, mostly illegible due to bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs or sections, with some lines being underlined. The handwriting is cursive and somewhat faded.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10466

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10390

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u> 1671-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>4626 Knox Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM Jeffrey BUGG</u>		4. DATE OF DEATH Month Day Year <u>9 23 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>9-22-60</u>	9. AGE (In years lost birthday) yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. <u>13 50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. E. BUGG, Jr.</u>		14. MOTHER'S MAIDEN NAME <u>Jane Souders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATELECTASIS OF NEWBORN</u> DUE TO <u>762.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PREMATURITY</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>SINCE BIRTH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-22, 1960</u> , to <u>9-23, 1960</u> , that (I) (we) last saw the deceased alive on <u>9-23 1960</u> , and that death occurred at <u>3:10 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Mary R. L. Sartwell,</u>		22b. DATE SIGNED <u>9-23-60</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>6811 RIGGS RD, HYATTSVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		23b. DATE THEREOF <u>9-23-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		23d. LOCATION (City, town, or county) (State) <u>8600 Old Georgetown Rd. Bethesda, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital</u>		25a. REC'D BY REGISTRAR <u>OCT 6 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Bethesda, Md.</u>			

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STATE OF TEXAS
COUNTY OF DALLAS

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TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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10467

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10391

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>60/10 Min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1111 Agnew Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Christine Campbell</u>		4. DATE OF DEATH Month Day Year <u>Sept 27 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-03</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11c. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Landgren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wilfred P. Campbell - Son</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIAL HYPERTENSION</u> (c) <u>CORONARY ARTERY DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 HRS.</u> <u>15 YEARS</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GASTRIC ULCER</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 27</u> 19 <u>60</u> to <u>Sept 27</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sept 27</u> 19 <u>60</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger</u>		22b. DATE SIGNED <u>Sept 27, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>		22d. ADDRESS <u>316 W. Montgomery Avenue Rockville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/1/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>—</u>	
25b. REGISTRAR'S SIGNATURE <u>—</u>		DATE <u>SEP 29 1960</u>	

CERTIFICATE OF DEATH

10683



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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10468

10392

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Ann Arundel ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 90 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 207 Claude Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucy Middle CARLE Last CARLE		4. DATE OF DEATH Month September Day 21 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-19-83
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Weippert		14. MOTHER'S MAIDEN NAME Mary Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (D) Mrs. Hilda M. Hardesty, Bethesda, Md.		4506 Chase Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from June 23, 1960 to Sept. 21, 1960 , that (I) (x) last saw the deceased alive on Sept. 21, 1960 , and that death occurred at 5:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE R. G. Muth		22b. DATE SIGNED 7-22-60	
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-24-60	
23c. NAME OF CEMETERY OR CREMATORY Louden Park Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, 6209 Elmbank Ave, Balto, Md.		25a. REC'D BY REGISTRAR DATE SEP 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Krasak			

North & Penna. Aves.

CERTIFICATE OF DEATH

10448

Name of Deceased		Age		Sex		Race		Religion		Marital Status		Occupation		Education		Place of Birth		Date of Birth		Date of Death		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		35		Male		White		Catholic		Single		Teacher		High School		New York		Jan 15 1920		Jan 16 1920		Heart Disease		New York		10:00 AM		J. A. Smith, M.D.		J. B. Jones, Registrar		J. C. Brown, Witness	
Name of Informant		Relationship		Address		City		State		Zip		Date of Report		Signature of Informant		Signature of Physician		Signature of Registrar		Signature of Witness		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
Jane Doe		Wife		123 Main St		New York		NY		10001		Jan 17 1920		J. A. Smith, M.D.		J. A. Smith, M.D.		J. B. Jones, Registrar		J. C. Brown, Witness		Heart Disease		New York		10:00 AM		J. A. Smith, M.D.		J. B. Jones, Registrar		J. C. Brown, Witness	
Name of Informant		Relationship		Address		City		State		Zip		Date of Report		Signature of Informant		Signature of Physician		Signature of Registrar		Signature of Witness		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar		Signature of Witness	
John Doe		Son		456 Elm St		New York		NY		10002		Jan 18 1920		J. A. Smith, M.D.		J. A. Smith, M.D.		J. B. Jones, Registrar		J. C. Brown, Witness		Heart Disease		New York		10:00 AM		J. A. Smith, M.D.		J. B. Jones, Registrar		J. C. Brown, Witness	

10469

CERTIFICATE OF DEATH

10393

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 2 HRS. 8 MIN.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First TERRY Middle LEE Last CARLIN				4. DATE OF DEATH Month SEPTEMBER Day 27 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/60	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Months 2 Days 8 Hours 2 Min. 8						10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JAMES DAVID CARLIN				14. MOTHER'S MAIDEN NAME OPAL MARIE WOOD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. HOSPITAL RECORDS,		17. INFORMANT OLNEY, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762-5 Sudden atelectasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumatury DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/27 , 19 60 , to 9/27 , 19 60 that I last saw the deceased alive on 9/27 , 19 60 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) SANDY SPRING, MD. DATE SIGNED 9/28/60							
ACTUAL SIGNATURE A. D. Bonifant		M.D. Sandy Spring, Md.					
PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		SANDY SPRING, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/60		22c. NAME OF CEMETERY OR CREMATORY Hyattstown Church Cem.		22d. LOCATION (City, town, or county) (State) Hyattstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE T. S. Wheeler 1331 E. Montg. Ave.-Rockville, Md.				24a. REC'D BY REGISTRAR SEP 29 '60		24b. REGISTRAR'S SIGNATURE Charles E. Howard	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

20732246XV2

CERTIFICATE OF DEATH

1963

(M)

IDENTIFICATION

HAT LAMB

DATE

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1 JANUARY

DEATH REPORT

1963

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10434 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10894

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>N. Cherry Chase</u>		c. LENGTH OF STAY IN lb <u>1 yr.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>N. Cherry Chase</u>		d. STREET ADDRESS <u>8804 Walnut Hill Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8804 Walnut Hill Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Elbert Chase</u>				4. DATE OF DEATH <u>Sept 22 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-11-1890</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone repair</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>			
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John T. Chase</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Louise Chase (wife)</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u> </u> (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. ACTUAL SIGNATURE <u>Frank J. Broschant</u>				22a. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
22b. EXAMINER'S NAME (Type) <u>FLANK J. Broschant</u>				22b. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22c. NAME (Type) <u>FLANK J. Broschant</u>				22c. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22d. ADDRESS (Street, city, town, or county) <u> </u>				22d. DATE SIGNED <u>9-22-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>9/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Prince Georges Co. Md.</u>	
23. FUNERAL DIRECTOR <u>The S.H.Hines Co.-2901 14th St. N.W.</u>				24a. REC'D BY REGISTRAR <u>SEP 26 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				24c. ADDRESS (Street, city, town, or county) <u>Washington, D.C.</u>			

10284 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

(I)

Signature: [illegible]
Date: [illegible]
Time: [illegible]

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10470

CERTIFICATE OF DEATH

Reg. Dist. No.

10395

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11904 CHARLES ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JENNIE Middle CHIPOURAS Last CHIPOURAS		4. DATE OF DEATH Month 9 Day 15 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/7/1888
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? Greece	
13. FATHER'S NAME Sam Zeavras		14. MOTHER'S MAIDEN NAME Staseni (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Angelo Chipouras-10707 Jamaica Drive		Address Silver Spring, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction massive DUE TO 260x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Hypertension DUE TO Diabetes mellitus (c) 10+ Yrs			INTERVAL BETWEEN ONSET AND DEATH sudden Years 10+ Yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 3 , 19 59 , to Sep 15 , 19 60 , that I lost saw the deceased alive on Sep 15 , 19 60 , and that death occurred at 9:30 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Abe Blajwas		M.D. 3900 -16th St. NW 9/15/60 Washington, D.C.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/17/60	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR DATE SEP 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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10396

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 18 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 2245 48th St., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Edward Last CLARK				4. DATE OF DEATH Month September Day 19 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-6-94	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William CLARK				14. MOTHER'S MAIDEN NAME Catherine FARRELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWI & WWII		17. INFORMANT Mrs. Marjorie S. CLARK, Same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Infection of Myocardium DUE TO (b) Coronary occlusion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) Atherosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Emphysema.				INTERVAL BETWEEN ONSET AND DEATH 11 months years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-1- 19 60 to 9-19- 19 60 that (I) (we) last saw the deceased alive on 9-19- 19 60 , and that death occurred at 6:28 AM from the causes and on the date stated above.							
22a. SIGNATURE Joseph E. Stitcher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-19-60	
22c. PHYSICIAN'S NAME (Type) J. E. STITCHER, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-22-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons				ADDRESS 1756 Penna Ave., N.W., Wash D.C.		25a. REC'D BY REGISTRAR SEP 20 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hume			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10472
CERTIFICATE OF DEATH

10397

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 103 Missouri Avenue, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ruth Middle Mary Last Clayton				4. DATE OF DEATH Month September Day 28 Year 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 14, 1924			
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Mgr.				10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) West Virginia			
13. FATHER'S NAME Willie D. Warfe				14. MOTHER'S MAIDEN NAME Ora Brady					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 240-22-5476		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widely disseminated carcinoma of the breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 170X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia								INTERVAL BETWEEN ONSET AND DEATH months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) September 13 19 60				20g. (County) September 28 19 60		20h. (State) Sept. 28 19 60			
21. I certify that (I) (this hospital) attended the deceased from Sept. 28 19 60 to Sept. 28 19 60 , that (I) (we) last saw the deceased alive on Sept. 28 19 60 , and that death occurred at 9:40 P.m. from the causes and on the date stated above.									
22a. SIGNATURE Leo Stolbach				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/29/60			
22c. PHYSICIAN'S NAME (Type) Leo Stolbach, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF OCT 1, 1960		23c. NAME OF CEMETERY OR CREMATORY UNK		23d. LOCATION (City, town, or county) (State) GREENSBORO, N.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4 St NE DC				ADDRESS 300-4 St NE DC		25a. REC'D BY REGISTRAR OCT 3 1960			
						25b. REGISTRAR'S SIGNATURE Arthur A. Frank			

The following information was received from the
National Bureau of Health Statistics, Washington, D.C.,
on January 10, 1941.

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On January 10, 1941, the following information was received from the
National Bureau of Health Statistics, Washington, D.C.,
on January 10, 1941.

CERTIFICATE OF DEATH

Reg. Dist. No.

10398

10473

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMANTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First CHARLES Middle WESLEY Last COE				4. DATE OF DEATH Month SEPT. Day 14 Year 19 60				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/83		
9. AGE (In years lost birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SAMUEL COE				14. MOTHER'S MAIDEN NAME ANNIE HAYES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Unknown		INFORMANT Address HOSPITAL RECORDS, OLNEY, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate with metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 177X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure from Anterior Septal A.D.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 56 , to 9/14 , 19 60 that I last saw the deceased alive on 9/14 , 19 60 , and that death occurred at 4:55 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE G. F. Meadors M.D.				ADDRESS (Street, city or town, state) BOYER CLINIC		DATE SIGNED 9/14/60		
PHYSICIAN'S NAME (Type) G. F. MEADORS, M. D.				DAMASCUS, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-60		22c. NAME OF CEMETERY OR CREMATORY Fredericksburg Conf. Fredericksburg, Virginia		22d. LOCATION (City, town, or county) (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonsville, Md.				24a. REC'D BY REGISTRAR DATE SEP 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanes		

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-1-73



INTERVIEWED

DATE OF DEATH

7 DAYS

CLINIC

ST. MARY'S HOSPITAL

DATE OF BIRTH

AGE

SEX

WHITE

CAUCASIAN

CONNECTION

NEW YORK

CERTIFICATE

WHITE MALE

UNKNOWN

UNKNOWN

HOSPITAL RECORDS

QUEST, NY

Center of the ...

Center of the ...

Center of the ...

DATE OF DEATH

DATE OF BIRTH

ST. MARY'S HOSPITAL, NEW YORK, N.Y.

ST. MARY'S HOSPITAL, NEW YORK, N.Y.

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10474

CERTIFICATE OF DEATH

Reg. Dist. No.

10399

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE Massachusetts b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boston			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 315 Commonwealth Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Dellow Cornish				4. DATE OF DEATH Month Day Year September 20 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 19, 1895	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George L. Hill				14. MOTHER'S MAIDEN NAME Franklina Hannahs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 030-20-6549		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Postoperative hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atrial Septal Defect DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 hours 65 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 31, 1960 , to September 20, 1960 , that I last saw the deceased alive on September 20, 1960 , and that death occurred at 11:00P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bethesda 14, Maryland 9/21/60							
ACTUAL SIGNATURE Benson R. Wilcox		M.D. The Clinical Center		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/26/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Propkrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE SEP 30 '60	
						24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10415

CERTIFICATE OF DEATH

10400

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hosp.		e. STREET ADDRESS 2508 Jennings Court	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Cozanas Last Cozanas		4. DATE OF DEATH Month Sept. Day 24 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/71
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired ?		10b. KIND OF BUSINESS OR INDUSTRY Greece	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Constantine Cozanas		14. MOTHER'S MAIDEN NAME Eva (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Washington San. & Hosp. Records.		Address Takoma Pk. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Congestive Heart failure DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriovascular accident; Pneumonia INTERVAL BETWEEN ONSET AND DEATH 7/29/60 - 7/24/60 - 105 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10, 1960 to 9/24, 1960 , that I last saw the deceased alive on 9/24 (no) 1960, and that death occurred at 7:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Michael M. Dobridge		M.D. 10620 ADDRESS (Street, city or town, state) Georgia Ave. Silver Spg. Md. DATE SIGNED 9/24/60	
PHYSICIAN'S NAME (Type) Michael M. Dobridge		10620 Georgia Ave. Silver Spg. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/60	
22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR DATE SEP 26 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

100

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10445 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10401											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg.					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 2 hrs		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Poolsville					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) B & O R R track						d. STREET ADDRESS 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles			First Charles Middle Craven Last			4. DATE OF DEATH Sept 8			Month Sept Day 8 Year 19 60		
5. SEX male		6. COLOR OR RACE col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/16		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44 Days 44	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Ma.				11. BIRTHPLACE (State or foreign country) USA			
13. FATHER'S NAME Mathew Craven						14. MOTHER'S MAIDEN NAME Lilly I. Driver					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) I				16. SOCIAL SECURITY NO. 1		17. INFORMANT Address USA					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration 8000X DUE TO crushed skull (skull practically decapated) Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) crushed skull (skull practically decapated) (c) crushed skull (skull practically decapated)										INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Reported walking along R R togo to mens room when struck by train											
20e. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) Reported walking along R R togo to mens room when struck by train							
20c. TIME OF INJURY Month, Day, Year 9:00 Hour 9/9/60 19 30 a.m. While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B & O R R		20f. (City or town) Kensington		(County) Montg.	
20f. (City or town) Kensington				20g. (County) Montg.		20h. (State) Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Frank J. Broschart						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
NAME (Type) Frank J. Broschart						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 9/11/60		22c. NAME OF CEMETERY OR CREMATORY Seneca		22d. LOCATION (City, town, or country) Seneca, Md.	
23. FUNERAL DIRECTOR Robert L. Luride						ADDRESS Rockville, Md.		24e. REC'D BY REGISTRAR SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Adams	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10396

CERTIFICATE OF DEATH

10402

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 11,943 CLARIDGE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLEN Middle JENNIE Last CUMMINGS		4. DATE OF DEATH Month SEPT. Day 25 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 27, 1898
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 12 Days 25 Hours 12 Min.	IF UNDER 24 HRS. Hours 12 Min.
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) CLERK GAO (retired)		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ORIN J. CUMMINGS	
14. MOTHER'S MAIDEN NAME ADELADE CASE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT Address Mrs. Allen R. Collier, 11,943 Claridge Road Silver Spring, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 124 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 7, 1940 , to Sept 25, 1960 , that (I) (we) last saw the deceased alive on Sept 24, 1960 , and that death occurred at 3 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W B Wardrop M.D.		22b. DATE SIGNED 9/26/60	
22c. PHYSICIAN'S NAME (Type) WILLIAM B. WARDROP		22d. ADDRESS 800 PERSHING DRIVE, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/27/60	
23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		25a. REC'D BY REGISTRAR DATE SEP 29 '60	
25b. REGISTRAR'S SIGNATURE Clifford S. Haines			

VI

Handwritten signature

Handwritten signature

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

104103
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville - Randolph Hills</u>	
c. LENGTH OF STAY IN <u>D.O.A.</u>		d. STREET ADDRESS <u>MONOGAHELA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>11515 Monongahela Dr. Randolph Hills</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael Joseph Danaher</u>		4. DATE OF DEATH <u>Sept 13 1960</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-1-60</u>	
9. AGE (In years last birthday) <u>12</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gerald J. Danaher</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Hormain</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>G. J. Danaher (father)</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>upper Respiratory Infection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>—</u> DUE TO <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in crib</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Knecht</u>	

MEDICAL CERTIFICATION

2074327XV5



Figure 2

10475

CERTIFICATE OF DEATH

10404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 9 Da	
d. NAME OF HOSPITAL (If not in hospital, give street address) Montg. Co. General Hospital		e. STREET ADDRESS North Summit Ave	
3. NAME OF DECEASED (Type or print) James Ernest Day		4. DATE OF DEATH Month Sept Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 4-1890
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 6 Days 25	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter & Painter, Retired		10b. KIND OF BUSINESS OR INDUSTRY Gaithersburg, Md.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Day		14. MOTHER'S MAIDEN NAME Joana Reed	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1-1919	
17. INFORMANT James E. Day, Jr.		Address Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular DUE TO Renal Disease (c) Years			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 15, 1960 to Sept. 29, 1960 that I last saw the deceased alive on Sept. 29, 1960 , and that death occurred at 10:00 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 105 Russell Ave. Gaithersburg, Md.		DATE SIGNED 9-29-60	
ACTUAL SIGNATURE Jack Schumacher			
PHYSICIAN'S NAME (Type) Jack Schumacher M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-2-60	22c. NAME OF CEMETERY OR CREMATORY Forest Oak	22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner		ADDRESS Gaithersburg, Md.	
24a. REC'D BY REGISTRAR DATE OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-1-30

DEPARTMENT OF COMMERCE

RECEIVED

RECEIVED

10-1-30

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10-1-30

U.S. DEPARTMENT OF COMMERCE

U.S. DEPARTMENT OF COMMERCE

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U.S. DEPARTMENT OF COMMERCE

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CORONER NOTIFIED AND RELEASED

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
10476 CERTIFICATE OF DEATH 10405										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>4 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Rockville</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>1305 N.W. Adams St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Nell</u> Middle <u>Graham</u> Last <u>Day</u>			4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>19 60</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7, 1932</u>		9. AGE (In years last birthday) <u>28</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Makes plastic dishes</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nemir Industries</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Tate Littrell</u>					14. MOTHER'S MAIDEN NAME <u>Elva Prater</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>		17. INFORMANT (Husband) <u>Norman Day</u>			Address <u>Rt. 1 - Gaithersburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> IMMEDIATE CAUSE (a) <u>Herniation of Brain Stem</u> DUE TO <u>Intracerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 hours</u> DUE TO (c) <u>Interval between onset and death</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5:45 PM</u> 19 <u>9/26/60</u> to <u>10:30 PM</u> when (I) (we) lost saw the deceased alive on <u>19</u> , and that death occurred at <u>10:30 PM</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Richard C. Myers</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD C. MYERS</u>					22d. ADDRESS <u>8512 Old Georgetown Rd. Bk 3</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>					ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>SEP 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

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074

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CERTIFICATE OF DEATH

10470

M

RECEIVED CIVIL SERVICE COMMISSION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

(M)

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MEDICAL CERTIFICATION

MAYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
10477													
10406													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyer</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Boyer</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>life</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Thomas Baker Daymude</u>						4. DATE OF DEATH <u>Sept 28 1960</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>2-26-95</u>		9. AGE (In years last birth day) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mail carrier</u>						11. BIRTHPLACE (State or foreign country) <u>md</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.E</u>	
13. FATHER'S NAME <u>Geo. Daymude</u>						14. MOTHER'S MAIDEN NAME <u>Ellen Mae Nicholson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>						16. SOCIAL SECURITY NO. <u>1915-1919 U.S. Marines</u>						17. INFORMANT <u>Petty Nicholson - Boyer md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Frank J. Broschart</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						<u>9-28-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>10/3/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boyer Presbyterian</u>		22d. LOCATION (City, town, or country) (State) <u>Boyer Md.</u>			
23. FUNERAL DIRECTOR <u>Constance C. Helton</u>						24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>		24b. REGISTRAR'S SIGNATURE		DATE <u>OCT 4 '60</u>			

PHYSICIAN'S CERTIFICATE OF DEATH

FILE NO.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10397

10407

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8716 BRADFORD ROAD				d. STREET ADDRESS 6121 WASHINGTON AVENUE			
3. NAME OF DECEASED (Type or print) First Middle Last EDMUND CARHART DILLON				4. DATE OF DEATH Month Day Year SEPT. 30 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/2/77	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter shopman (retired)				10b. KIND OF BUSINESS OR INDUSTRY Bureau of Water		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES DILLON				14. MOTHER'S MAIDEN NAME ELLEN CARHART			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Peter Kell, 8716 Bradford Rd. #6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO CORONARY ATHEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 14 yrs. DUE TO (c) 10 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SECONDARY ANEMIA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from April 1960 to 9/30 , 19 60 , that (I) (we) last saw the deceased alive on 9/30 , 19 60 , and that death occurred at 10 P. M, from the causes and on the date stated above.							
22a. SIGNATURE Lee B. Snow				22b. ADDRESS 7950 NewHampshire Ave., Langley Park, Md.			
22c. PHYSICIAN'S NAME (Type) LEE B. SNOW				22d. ADDRESS 7950 NewHampshire Ave., Langley Park, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL				23b. DATE THEREOF 10/4/60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY	
23d. LOCATION (City, town, or county) (State) DREXEL HILL, PENNSYLVANIA							
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.				25a. REC'D BY REGISTRAR DATE OCT 4 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Puma	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

14 yrs.
10 yrs.

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

22. DATE SIGNED
10/1/60

Secretary of the Board
of Directors

Secretary of the Board

Aug. 14 - 1933

1933

1933

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10456 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10408

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md</i> b. COUNTY <i>montg</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>			
c. LENGTH OF STAY IN 1b <i>6 yrs</i>				d. STREET ADDRESS <i>1102 Parviz Dr</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>1102 Parviz Dr</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Dorothy Inez Dodd</i>				4. DATE OF DEATH <i>Sept 10 1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 10, 1933</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>27</i>		10. IF UNDER 1 YEAR <i>5</i> Months <i>0</i> Days		11. IF UNDER 24 HRS. <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>				13. FATHER'S NAME <i>Samuel Hunter</i>			
14. MOTHER'S MAIDEN NAME <i>Mayhew</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			
16. SOCIAL SECURITY NO. <i>None</i>				17. INFORMANT <i>Arac Dodd (husband)</i> Address <i>Stn 2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>974X</i> DUE TO <i>Strangling</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hung self in attache of her home</i>			
20c. TIME OF INJURY Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Bloeschart</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>FRANK J. Bloeschart</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>9/14/60</i>			
22c. NAME OF CEMETERY OR CREMATORY <i>Rockville Cemetery</i>				22d. LOCATION (City, town, or country) (State) <i>Rockville, Maryland</i>			
23. FUNERAL DIRECTOR <i>Robert A. Pumphrey</i>				24a. REC'D BY REGISTRAR <i>SEP 14 '60</i>			
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>				DATE <i>9-10-60</i>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10499

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>4 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> <u>14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Anne's Hospital</u>		d. STREET ADDRESS <u>1006 Orchard Way</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Stephen Arnold Douglas</u>		4. DATE OF DEATH <u>9</u> Month <u>1</u> Day <u>1960</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-83</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tiffanys Jewelry</u>	11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Isaac Douglas</u>		14. MOTHER'S MAIDEN NAME <u>Annie Brenton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>056-10-1788</u>	17. INFORMANT <u>p't Hosp Record</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypoproteinemia</u> DUE TO (c) <u>CARCINOMA OF STOMACH</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1-2 yrs.</u> <u>2-3 months</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nutritional Cirrhosis of liver</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> <u>1955</u> to <u>Sept 2</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 1</u> <u>1960</u> , and that death occurred at <u>6:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert B. Irey</u>		22b. DATE SIGNED <u>9-2-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>		22d. ADDRESS <u>7105 Rigg Rd. Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>9/6/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>
23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 '60</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

STATE OF TEXAS
COUNTY OF DALLAS

1910

(M)

(S)

(C)

(H)

(I)

(J)

(K)

(L)

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10478

10410

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE FLORIDA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Cove Springs		48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 734 N. Pine Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nazarine Middle DOWDEN Last DOWDEN		4. DATE OF DEATH Month September Day 28 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-20-11
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Horace CHAMBERS		14. MOTHER'S MAIDEN NAME Alberta HECKNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 264-16-3108	
17. INFORMANT (H) Edw. J. Dowden, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respirators Arrest DUE TO (b) Brain metastasis of. DUE TO (c) Sq Cell Carcinoma Cervicofacial Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous Cell Carcinoma metastatic to lung		INTERVAL BETWEEN ONSET AND DEATH 1 yrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) did not attended the deceased from Sept. 17 19 60 to Sept. 28 19 60 that (I) was last saw the deceased alive on Sept. 28 19 60 , and that death occurred at 10:50AM M, from the causes and on the date stated above.			
22a. SIGNATURE R. F. Mading		22b. DATE SIGNED 9-28-60	
22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 9-29-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Green Cove Springs Florida	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Snowden Funeral Home, Rockville, Md.		25a. REC'D BY REGISTRAR DATE SEP 30 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10398 CERTIFICATE OF DEATH 10411

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 19 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,604 LORAIN AVENUE		d. STREET ADDRESS 1 10,604 LORAIN AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE GERTRUDE DUNBAR		4. DATE OF DEATH Month Day Year SEPT. 25 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 4, 1881
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELIUS WHELAN		14. MOTHER'S MAIDEN NAME ALICE BLANCHFIELD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Richard C. Dunbar, 10,604 Lorain Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 30 min 7 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/26 1950 to 9/25/60 19 that (I) (we) lost saw the deceased alive on 9/21 1960, and that death occurred at 1 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Marion Bankhead M.D.		22b. DATE SIGNED 9/25/60	
22c. PHYSICIAN'S NAME (Type) J. MARION BANKHEAD		22d. ADDRESS 9421 Columbia Blvd., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/29/60	
23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		23d. LOCATION (City, town, or county) (State) FOREST GLEN, MONT. COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE WALTER E. BUMBERRY, INC. Raymond E. Biska		25a. REC'D BY REGISTRAR DATE SEP 30 '60	
25b. REGISTRAR'S SIGNATURE Caring L. Hume			

STATE OF OHIO
DEPARTMENT OF HEALTH

REPORT OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR
1911

THE
DEPARTMENT OF HEALTH
OF THE
STATE OF OHIO
HAS THE HONOR TO
PRESENT TO THE
LEGISLATURE
THIS REPORT
FOR THE YEAR
1911

THE
DEPARTMENT OF HEALTH
OF THE
STATE OF OHIO
HAS THE HONOR TO
PRESENT TO THE
LEGISLATURE
THIS REPORT
FOR THE YEAR
1911

Wm. H. ...
1911

1039.3 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10412

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>21 yrs</u>				d. STREET ADDRESS <u>12510 Brigg Chaney Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2510 Brigg Chaney Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bessie Banks Duwall</u>				4. DATE OF DEATH <u>9-13-60</u> 19 <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-28-1896</u> 64 yrs.	
9. AGE (In years last birthday) <u>64</u>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>			
11. BIRTHPLACE (State or foreign country) <u>md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Frank Woodward</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Spencer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>Frank W. Duwall (son)</u>			
17. INFORMANT <u>Silver Spring md</u>				Address <u>2600 Brigg Chaney Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexia</u> DUE TO <u>Stomach</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Stomach</u> (c) <u>Stomach</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Hung self by neck in attic of her home</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>attic of her home</u>				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>9-13-60</u>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept 16, 1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Burtonsville, Md.</u>			
23. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll St NW SE</u>				24a. REC'D BY REGISTRAR <u>SEP 15 '60</u>			
ADDRESS				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

ACTUAL SIGNATURE Frank J. Bloeschant
EXAMINER'S NAME (Type) FRANK J. Bloeschant

2

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO. 100-111111

100-111111

100-111111

100-111111

100-111111

100-111111

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10400 **CERTIFICATE OF DEATH** **10413**

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,102 Ga. Ave., Apt. #102				d. STREET ADDRESS 10,102 Ga. Ave., Apt. #102			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Edward Middle Benedict Last Dyer				4. DATE OF DEATH Month Sept Day 24 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 19, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY WABASH RAILROAD		11. BIRTHPLACE (State or foreign country) TOPEKA, KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD P. DYER				14. MOTHER'S MAIDEN NAME ELLEN MCCARTHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW #1		17. INFORMANT Mrs. Mary J. Dyer, 10,102 Ga. Ave., Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Insufficiency DUE TO (c) Coronary Artery Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 1 day 5 yrs							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour am p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 24 Sept 1960 to 24 Sept 1960 that (I) (we) last saw the deceased alive on 24 Sept 1960 and that death occurred at 8:55 PM from the causes and on the date stated above.							
22a. SIGNATURE Merton L. White				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 24 Sept 60	
22c. PHYSICIAN'S NAME (Type) MERTON L. WHITE				22d. ADDRESS 11134 Georgia Ave, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/27/60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond C. Ziska				25a. REC'D BY REGISTRAR DATE SEP 29 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10479 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10414

Item 7 Film 6271 9-25-60 et

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any further action is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown, R-2 c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Berryville Rd.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown R-2 d. STREET ADDRESS Berryville Rd. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence Elizabeth Prather Dyson First Middle Last 4. DATE OF DEATH Sept 13 19 60 Month Day Year		5. SEX female 6. COLOR OR RACE col. 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 6/19/16 9. AGE (In years last birthday) 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) MD. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Prather 14. MOTHER'S MAIDEN NAME Bertha Draper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Mary Prather (sister) Address Item 2		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure 434.1 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 9/13/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 9/16/60 22c. NAME OF CEMETERY OR CREMATORY Poolesville, 22d. LOCATION (City, town, or country) (State) Poolesville, Md.		23. FUNERAL DIRECTOR Robert L. Suroden ADDRESS Rockville, Md. 24a. REC'D BY REGISTRAR SEP 19 '60 24b. REGISTRAR'S SIGNATURE Arthur S. House	

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Frank J. Broschart
Frank J. Broschart

M.D.

DATE SIGNED

THE STATE
HEALTH DEPT.

(M)

(Y)

STATE DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

one copy to be retained by the medical examiner and one copy to be forwarded to the State Department of Health.

1. Name of deceased: James Alexander Fraser Lyon

2. Sex: Male

3. Age: 60/10

4. Date of birth: Jan 13 1888

5. Place of birth: London, England

6. Usual residence: London, England

7. Cause of death: Heart failure

8. Manner of death: Natural

9. Signature of medical examiner: Frank A. Thompson

10. Date: Jan 13 1948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10415

10480

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Illinois</u> b. COUNTY <u>Adams</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clayton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>SIX-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>B. Ellerbroek</u> Last <u>Nettie B. Ellerbroek</u>		4. DATE OF DEATH Month <u>9</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Clayton, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>James Jefferson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Foster</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Eva Kaufmann Olney-Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebotrombosis of Femoral vein</u> 15 min DUE TO (c) <u>Sen. art. Sclerosis + Debility</u> 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 MIA</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-9</u> <u>1959</u> to <u>13 Aug</u> <u>1960</u> that (I) (we) last saw the deceased alive on <u>13 Aug</u> <u>1960</u> and that death occurred at <u>10:15</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>John Bosley Ziegler</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>		22d. ADDRESS <u>Olney Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9-17-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Clayton, Illinois</u>		23d. LOCATION (City, town, or county) (State) <u>Clayton, Illinois</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 15 '60</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

CERTIFICATE OF DEATH

104-40

[Faint, mostly illegible handwritten text, likely a death certificate form with fields for name, date, and cause of death.]

CLAYTON, ILLINOIS
CLAYTON, ILLINOIS
CLAYTON, ILLINOIS

10481

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKDALE, MD.</u>			
c. LENGTH OF STAY IN 1b <u>18 days</u>				d. STREET ADDRESS <u>4707 Overbrook Rd</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverley Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Georgia</u> First <u>G.</u> Middle <u>Ellis</u> Last				4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-21-1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>			
11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>GEORGE POOLE</u>				14. MOTHER'S MAIDEN NAME <u>Wolf</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Louis P. Alturine</u> Address <u>1471 Rockville Rd, Rockville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> 420-0 DUE TO Semi (c) <u>Cholelithiasis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June, 1959</u> , to <u>Sept 17, 1960</u> , that I last saw the deceased alive on <u>9-17</u> , 1960 and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. P. Andrews M.D.</u> M.D. <u>4201 Essenden St. N.W. Washington, D.C.</u>				DATE SIGNED <u>9-17-60</u>			
PHYSICIAN'S NAME (Type) <u>P. P. ANDREWS M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/20/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Howard</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10482

10417

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami	
c. LENGTH OF STAY IN 1b 16 days		d. STREET ADDRESS 11100 Griffing Blvd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Corinne Middle Ellis Last FAILING		4. DATE OF DEATH Month September Day 10 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-17-96
9. AGE (In years last birthday) yrs. 64		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Ellis		14. MOTHER'S MAIDEN NAME Louise House	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Rollin Failing		Address 11100 Griffing Blvd Miami, Fla.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peripheral vascular collapse DUE TO (b) Post OPERATIVE SEPSIS & PYELONEPHRITIS & PNEUMONIA DUE TO (c) Extensive carcinoma urinary bladder			INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 3 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-25 19 60 to 9-10-60 19 , that (I) (we) last saw the deceased alive on 9-10 19 60 , and that death occurred at 8:25 PM on the causes and on the date stated above.			
22a. SIGNATURE J. D. Real		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J.D. REAL LT MC USN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-14-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		25a. REC'D BY REGISTRAR SEP 13 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		25c. ADDRESS 7557 Wis. Ave Bethesda, Md.	

MEDICAL CERTIFICATION

U.S. DEPARTMENT OF STATE

Washington (1001)

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

Office of the Secretary of State
Division of Intelligence
Room 5610
Washington, D.C.

New York
London
Paris

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

U.S. DEPARTMENT OF STATE, WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

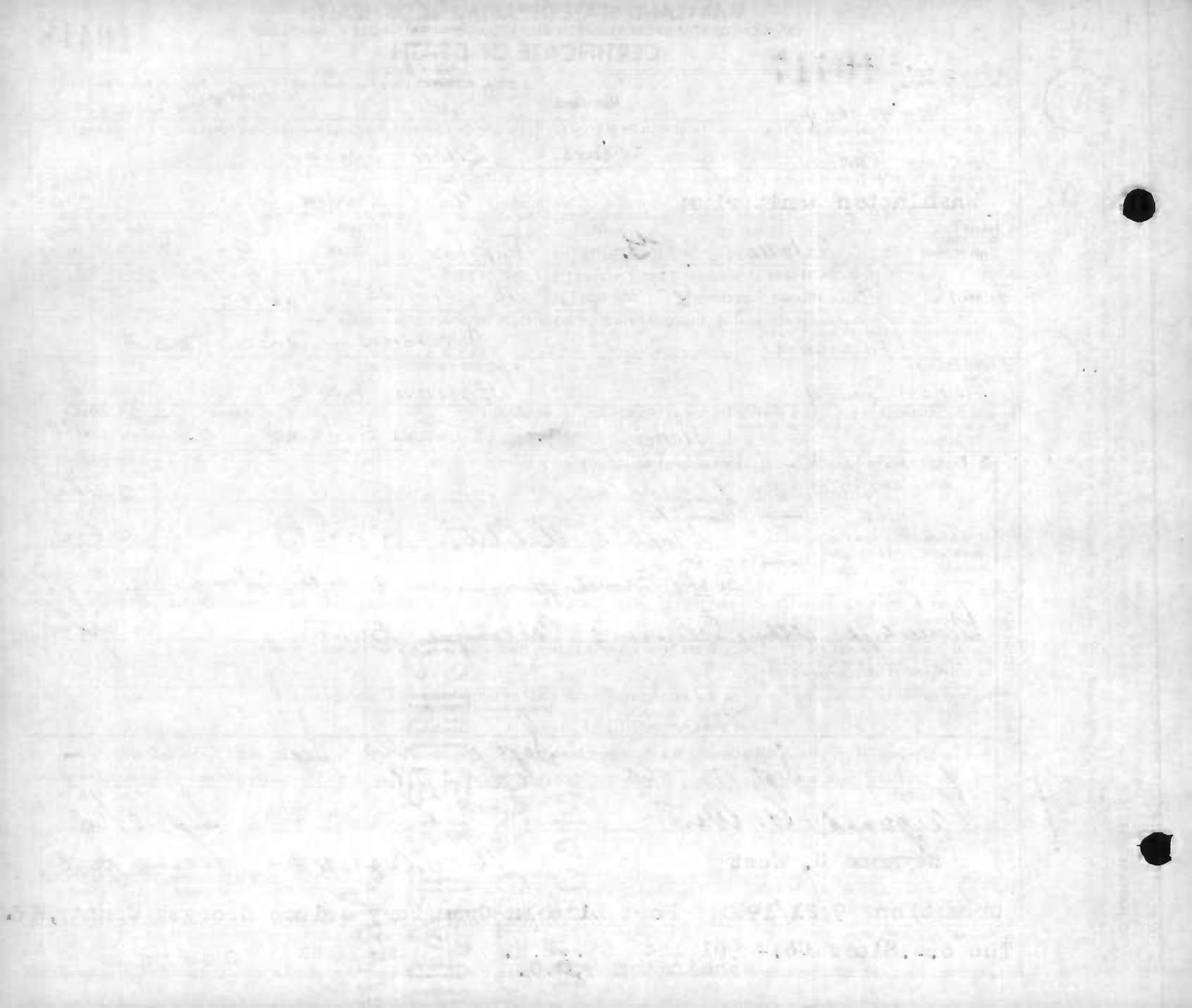
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10417

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10418

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>9301 Weaver St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Estella</u> Middle <u>Y</u> Last <u>Figgins</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-17-73</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>American - D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Sewell</u>		14. MOTHER'S MAIDEN NAME <u>Estella Hear</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Thomas S. Israel</u> Address <u>S.S. Md. 10304 Inwood Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>544-1</u> <u>Uremia with Gastric Dilatation (acute)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>with</u> DUE TO (b) <u>Early Broncho pneumonia + pulm Edema</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign Hypertension, Arteriosclerosis, Carcinoma Breast</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 hrs</u> <u>"</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> 19 <u>60</u> to <u>Sept 17</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Sept 17</u> 19 <u>60</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Raymond O. West</u>		22b. DATE SIGNED <u>Sept 18/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>		22d. ADDRESS <u>7600 Carver Ave, Takoma Park</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>9/21/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory Prince Georges County, Md</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co.-2901 14th St. N.W. Washington 9, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 20 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10419

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda-Poolesville D.O. A.</u>			c. LENGTH OF STAY IN 1b <u>Suburban</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Poolesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Poolesville Route #107</u>				d. STREET ADDRESS <u>Route # 107</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Boy</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>25</u> Year <u>19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 25, 1960</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mont. co</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>George Barnes</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Fisher</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mother's Chart,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> 760.5 DUE TO <u>Birth Trauma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Prematurity</u> (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval BETWEEN ONSET AND DEATH</u> <u>Minutes</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert K. Swander</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 3 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

9VVVVVVUXVV

TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10446
CERTIFICATE OF DEATH

10420

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens		d. STREET ADDRESS 9701 Glen Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTELLE Middle C. Last FLOYD		4. DATE OF DEATH Month Sept. Day 7, Year 19 60	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 8 Days 12 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Alfonso W. Carlett		14. MOTHER'S MAIDEN NAME ? Reavis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT F. Scott Collins-son-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EMBOLUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UREMIA DUE TO (c) CARCINOMA OF LUNG		INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 DAYS 12 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 5, 1960 , to SEPT. 7, 1960 , that (I) <u>we</u> lost the deceased alive on SEPT 5, 1960 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Gordon S. Rosenberger		22b. DATE SIGNED Sept. 7/60	
22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger, M. D.		22d. ADDRESS 310 W. MONTGOMERY AVE. ROCKVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/9/60	
23c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		23d. LOCATION (City, town, or county) (State) Potomac, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE SEP 13 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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10484
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10421

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>3hrs. 45min.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Foreman</u>		4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>19 60</u>	
S. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>September 10, 1960</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Foreman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Budd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5 Congenital heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Interventricular defect</u> (c) <u>atelectasis of lungs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/10</u> to <u>9/10</u> , that (I) (we) last saw the deceased alive on <u>9/10</u> 19 <u>60</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Gilcin F. Meadors</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Gilcin F. Meadors, MD.</u>		22d. ADDRESS <u>Damascus, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/13/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Sandy Spring, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>			

2073418XV5

CERTIFICATE OF DEATH

1944

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

FILE

CERTIFICATE NO.

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

Item 20 Filed 271 9-29-60 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10401 CERTIFICATE OF DEATH

10422

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2311 WEST VIEW DRIVE		d. STREET ADDRESS 2311 WEST VIEW DRIVE	
3. NAME OF DECEASED (Type or print) First ROSE Middle H. FRIEDMAN Last FRIEDMAN		4. DATE OF DEATH Month 9 Day 22 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 8 - 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 6 Days 9 Hours 15 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY NEW YORK	
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MICHAEL HAMERMAN (DEC.)		14. MOTHER'S MAIDEN NAME SARAH BELLE KATZ (DEC.)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT HARRY FRIEDMAN		Address 2311 WESTVIEW DR.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolization - Pulmonary DUE TO 904.0 CORONARY HEART DISEASE - one heart. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left knee - Recent. (c) Fracture left knee - Recent.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 0		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Silver Spring (County) Montg (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Aug 1960 to Sept 1960 , that (I) (we) last saw the deceased alive on 9-21-1960 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Ad J Vosger m.d.		22b. DATE SIGNED 9-22-60	
22c. PHYSICIAN'S NAME (Type) Ad J Vosger m.d.		22d. ADDRESS 3810 Blackthorn Ct. Choc Ma.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sep. 26, 1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		23d. LOCATION (City, town, or county) D.C. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Seadeg Funeral Home		25a. REC'D BY REGISTRAR 4217 9th St. N.W.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE SEP 26 '60	

CERTIFICATE OF DEATH

1941

(M)

(1)

Dec. 26, 1940 Cedar Hill, Pa.

Dec. 26, 1940 Cedar Hill, Pa.

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10423

10418

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>905 Domer Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Noel</u> Middle <u>Eugene</u> Last <u>Gleyzal</u>				4. DATE OF DEATH Month <u>September</u> Day <u>3</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-21-72</u>			
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>7</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chex</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>France</u>			
13. FATHER'S NAME <u>Louis Gleyzal</u>				14. MOTHER'S MAIDEN NAME <u>Augustine Mantelin</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral + pulmonary edema</u> DUE TO (b) <u>Malnutrition</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <u>Carcinoma, fibrosis of tongue</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>slap</u> <u>month</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-6</u> <u>1960</u> to <u>9-3</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>9-3</u> <u>1960</u> , and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Abraham W. Danish</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-4-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>				22d. ADDRESS <u>927 PERSHING Dr. S.S.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify).		23b. DATE THEREOF <u>Sept. 7-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Nicholas Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Bladensburg Road. D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u>				ADDRESS <u>254 Carroll St. NW.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>			
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1988



OFFICE OF THE ATTORNEY GENERAL

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OFFICE OF THE ATTORNEY GENERAL

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10485
CERTIFICATE OF DEATH

10424

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESMOR SANITARIUM		d. STREET ADDRESS 5309 Burling Terrace	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR E. GOODWIN, Sr.		4. DATE OF DEATH Month Day Year Sept. 23, 19 60	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1884
9. AGE (In years last birthday) 76		IF UNDER 1 YEAR Months Days Hours Min. 8 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Agent		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Henry Goodwin		14. MOTHER'S MAIDEN NAME Katie M. Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Son		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate 181.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with multiple metastases DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> NOT while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 60 to 23 Sept 60 , that (I) (we) last saw the deceased alive on 23 Sept 19 60 and that death occurred at 6:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE H. Richwine		22b. DATE SIGNED 23 Sept 60	
22c. PHYSICIAN'S NAME (Type) H. RICHWINE, MD		22d. ADDRESS 5522 WESTERN AVE CHRY CHASE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-24-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) Boston, Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE SEP 27 '60	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

(1)

Guinness & Co. Ltd.
21, Abchurch Lane, London, E.C. 4

21, Abchurch Lane, London, E.C. 4
Guinness & Co. Ltd.
21, Abchurch Lane, London, E.C. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10425

10486

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 39 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY New York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York d. STREET ADDRESS 530 Riverside Dr. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Raphael Last GOTTSLIEB		4. DATE OF DEATH Month September Day 1 Year 19 60			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-23-29	9. AGE (In years last birthday) 30 yrs.	IF UNDER 1 YEAR Months 30 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Service Officer		10b. KIND OF BUSINESS OR INDUSTRY New York		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Israel Davidson GOTTSLIEB		14. MOTHER'S MAIDEN NAME Helen Ronald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Helen GOTTSLIEB, same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 200.1 DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 160		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-26-60 to 9-1-1960 , that (I) (we) last saw the deceased alive on 9-1-1960 , and that death occurred at 9:35 PM from the causes and on the date stated above.					
22a. SIGNATURE L. HINES		22b. DATE SIGNED 9-2-60			
22c. PHYSICIAN'S NAME (Type) L. HINES, CDR, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-6-60		23c. NAME OF CEMETERY OR CREMATORY Baron Hirsch	
23d. LOCATION (City, town, or county) Staten Island, New York					
24. FUNERAL DIRECTOR'S SIGNATURE DANZANSKI		24a. ADDRESS 3501 14th Street, N.W., Wash., D.C.		25a. REC'D BY REGISTRAR SEP 8 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline					

14

10-18-48

CERTIFICATE OF DEATH

DATE OF DEATH

NEW YORK

(10-18-48)

NEW YORK

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

3

U.S. Navy Hospital, Brooklyn, N.Y.

NEW YORK

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

U.S. Navy Hospital, Brooklyn, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10426

10487

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Key West c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Key West d. STREET ADDRESS Sugar Loaf Shores e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last John Leonodis GOULDER		4. DATE OF DEATH Month Day Year September 24 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-10
9. AGE (In years last birthday) yrs. 50		IF UNDER 1 YEAR Months Days Hours Min. 50	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Milton GOULDER		14. MOTHER'S MAIDEN NAME Marie Elizabeth (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1932 to DOD		16. SOCIAL SECURITY NO. 554-34-1259	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Insufficiency DUE TO (b) Metastatic carcinoma of liver DUE TO (c) Bronchiogenic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the undersigned) attended the deceased from Sept. 20 19 60 to Sept. 24 19 60 that (I) (we) last saw the deceased alive on Sept. 24 19 60 and that death occurred at 11A M from the causes and on the date stated above.			
22a. SIGNATURE William P. Baker		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 9-25-60	
22c. PHYSICIAN'S NAME (Type) William P. BAKER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - shipment 9-26-60		23b. DATE THEREOF 9-26-60	
23c. NAME OF CEMETERY OR CREMATORY Blandford Cemetery		23d. LOCATION (City, town, or county) (State) Petersburg Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey R.A. Pumphrey Funeral Home, Bethesda, Md.		25a. REC'D BY REGISTRAR SEP 28 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

M

William B. Baker, Jr., M.D.

U.S. Naval Hospital, Bethesda, Md.

John

Washington

U.S. Navy

Virginia

William B. Baker, Jr., M.D.

U.S. Naval Hospital, Bethesda, Md.

CHIEF

2000

William B. Baker, Jr., M.D.

U.S. Naval Hospital, Bethesda, Md.

Washington

Virginia

U.S. Naval Hospital, Bethesda, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10488

10427

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 266 days		d. STREET ADDRESS 2014 Gosnell Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Sybil Last Grant		4. DATE OF DEATH Month September Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 30, 1924
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 3 Days 9 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jonas A. Hammond		14. MOTHER'S MAIDEN NAME Ira B. Lyon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choriocarcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 173X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 18, 19 59 to September 9, 19 60 , that (I) (we) last saw the deceased alive on September 9, 19 60 , and that death occurred at 4:01 AM from the causes and on the date stated above.			
22a. SIGNATURE Martin Nydick		22b. DATE SIGNED 9/9/60	
22c. PHYSICIAN'S NAME (Type) Martin Nydick, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF SEPT. 12 1960	
23c. NAME OF CEMETERY OR CREMATORY Washington		23d. LOCATION (City, town, or county) (State) TROUP, TEXAS	
24. FUNERAL DIRECTOR'S SIGNATURE Charles S. Kneass		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
ADDRESS 816 1st St NE		25b. REGISTRAR'S SIGNATURE Charles S. Kneass	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10428

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4201 Mass. Ave. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>47X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Emerson</u> Last <u>Greer</u>		4. DATE OF DEATH <u>Sept 27</u> 19 <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 26 1891</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Rep. XXXXXX</u>		9b. AGE (In years last birthday) <u>68</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY <u>Automotive</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
13. FATHER'S NAME <u>Robert Greer</u>		14. MOTHER'S MAIDEN NAME <u>Ida Sherwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>War I</u>		16. SOCIAL SECURITY NO. <u>577-03-5844</u>	
17. INFORMANT <u>wife</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of atherosclerotic aneurysm, abdom.</u> <u>45 IX</u> DUE TO (b) <u>Generalized atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>nat abrtg</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 27, 1960</u> to <u>Sept 27, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 27, 1960</u> , and that death occurred on <u>Sept 27, 1960</u> at <u>10:25</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Barnton</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Barnton, M.D.</u>		22d. ADDRESS <u>10511 Summitt Ave., Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/30/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>washington, D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 29 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

Chen

3

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10429

10490

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>1 hr.</u>		d. STREET ADDRESS <u>1803 Monroe Street, N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>A.</u> Last <u>Griffith</u>		4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rev. Frank T. Griffith</u>		14. MOTHER'S MAIDEN NAME <u>Kate Kenny Beaty</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Sister</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardis Vascular</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH. <u>5 hrs.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 2</u> 19 <u>60</u> to <u>Sept 18</u> 19 <u>60</u> that (I) (we) lost saw the deceased alive on <u>Sept 10</u> 19 <u>60</u> and that death occurred at <u>8 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James E. Nolan</u> M.D.		22b. DATE SIGNED <u>9-19-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES E. Nolan</u>		22d. ADDRESS <u>5401 Western Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/20/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friendship, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company- Washington, DC</u>		25a. REC'D BY REGISTRAR <u>SEP 20 '60</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-23-37

CERTIFICATE OF DEATH

11-23-37



Funeral Home, Inc.

Funeral Home, Inc.

Funeral Home, Inc.

10491

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10430

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 6302 Orchid Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Herbert Middle William Last HAAS				4. DATE OF DEATH Month September Day 20 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-07	
9. AGE (In years lost birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitary Engineer				10b. KIND OF BUSINESS OR INDUSTRY U.S.Public Health		11. BIRTHPLACE (State or foreign country) Wisconsin	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Edward HAAS				14. MOTHER'S MAIDEN NAME Augusta Louise ABEL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 013-28-9290		17. INFORMANT Address (W) Mrs. Helen P. Haas, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 364X DUE TO Neuritis, Brain stem Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Schapathic Polymyositis 14 Days (c) Arteriosclerotic Heart Disease 2+ years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 Sept. 8, 1960 3:45 PM 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) H. F. O'Connell attended the deceased from Sept. 8, 1960 to Sept. 20, 1960 , that (I) (X) last saw the deceased alive on Sept. 20, 1960 , and that death occurred at 3:45 PM from the causes and on the date stated above.							
22a. SIGNATURE H. F. O'Connell				22b. DATE SIGNED 9-21-60			
22c. PHYSICIAN'S NAME (Type) H. F. O'CONNELL, LCDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisc. Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10-31

CERTIFICATE OF DEATH

10-31

(M)

U.S. Social Security Administration
Washington, D.C. 20535
Date of Death: 10-31-68
Place of Death: Home
Cause of Death: Heart Disease
Age: 78
Sex: Male
Race: White
Marital Status: Married
Occupation: Retired
Signature: [Signature]
Printed Name: [Name]
Address: [Address]
City: [City]
State: [State]
Zip: [Zip]

1

10492

CERTIFICATE OF DEATH

10431

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIJAH Middle ---- Last HACKETT				4. DATE OF DEATH Month SEPTEMBER Day 7 Year 1960			
5. SEX MALE		6. COLOR OR RACE COLORED		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-25-1875	
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY HACKETT				14. MOTHER'S MAIDEN NAME MARTHA AWKWARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT HOSPITAL RECORDS OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 593X IMMEDIATE CAUSE (a) HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) UREMIA DUE TO (c) KIDNEY FAILURE							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from AUGUST 31 , 19 60 , to SEPT. 7 , 19 60 , that I last saw the deceased alive on SEPT. 7 , 19 60 , and that death occurred at 10:20 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) GAITHERSBURG, MARYLAND DATE SIGNED 9/8/60							
ACTUAL SIGNATURE L. I. LEAL, M. D. M.D.							
PHYSICIAN'S NAME (Type) L. I. LEAL, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/10/60		22c. NAME OF CEMETERY OR CREMATORY Ash Memorial,		22d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE SEP 13 '60	
				24b. REGISTRAR'S SIGNATURE Orlando L. Hume			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10-22

DECEASED: [Name] [Address] [City] [State] [Zip]

DATE OF DEATH: [Date] TIME OF DEATH: [Time]

PLACE OF DEATH: [Location]

CAUSE OF DEATH: [Cause]

DECEASED'S SIGNATURE: [Signature]

WITNESSES: [Signatures]

DEATH CERTIFICATE NO. [Number]

FILED: [Date]

REGISTERED: [Date]

DECEASED'S AGE: [Age]

DECEASED'S SEX: [Sex]

DECEASED'S RACE: [Race]

DECEASED'S RELIGION: [Religion]

DECEASED'S OCCUPATION: [Occupation]

DECEASED'S MARITAL STATUS: [Status]

DECEASED'S EDUCATION: [Education]

DECEASED'S BIRTH DATE: [Date]

DECEASED'S BIRTH PLACE: [Place]

DECEASED'S BIRTH TIME: [Time]

DECEASED'S BIRTH WEIGHT: [Weight]

DECEASED'S BIRTH LENGTH: [Length]

DECEASED'S BIRTH HEAD CIRCUMFERENCE: [Circumference]

DECEASED'S BIRTH ARM CIRCUMFERENCE: [Circumference]

DECEASED'S BIRTH LEG CIRCUMFERENCE: [Circumference]

DECEASED'S BIRTH SKIN COLOR: [Color]

DECEASED'S BIRTH HAIR COLOR: [Color]

DECEASED'S BIRTH EYE COLOR: [Color]

DECEASED'S BIRTH MOUTH COLOR: [Color]

DECEASED'S BIRTH NOSE COLOR: [Color]

DECEASED'S BIRTH EAR COLOR: [Color]

DECEASED'S BIRTH FINGER COLOR: [Color]

DECEASED'S BIRTH TOE COLOR: [Color]

DECEASED'S BIRTH NAIL COLOR: [Color]

DECEASED'S BIRTH SKIN CONDITION: [Condition]

DECEASED'S BIRTH HAIR CONDITION: [Condition]

DECEASED'S BIRTH EYE CONDITION: [Condition]

DECEASED'S BIRTH MOUTH CONDITION: [Condition]

DECEASED'S BIRTH NOSE CONDITION: [Condition]

DECEASED'S BIRTH EAR CONDITION: [Condition]

DECEASED'S BIRTH FINGER CONDITION: [Condition]

DECEASED'S BIRTH TOE CONDITION: [Condition]

DECEASED'S BIRTH NAIL CONDITION: [Condition]

DECEASED'S BIRTH SKIN TONE: [Tone]

DECEASED'S BIRTH HAIR TONE: [Tone]

DECEASED'S BIRTH EYE TONE: [Tone]

DECEASED'S BIRTH MOUTH TONE: [Tone]

DECEASED'S BIRTH NOSE TONE: [Tone]

DECEASED'S BIRTH EAR TONE: [Tone]

DECEASED'S BIRTH FINGER TONE: [Tone]

DECEASED'S BIRTH TOE TONE: [Tone]

DECEASED'S BIRTH NAIL TONE: [Tone]

DECEASED'S BIRTH SKIN TYPE: [Type]

DECEASED'S BIRTH HAIR TYPE: [Type]

DECEASED'S BIRTH EYE TYPE: [Type]

DECEASED'S BIRTH MOUTH TYPE: [Type]

DECEASED'S BIRTH NOSE TYPE: [Type]

DECEASED'S BIRTH EAR TYPE: [Type]

DECEASED'S BIRTH FINGER TYPE: [Type]

DECEASED'S BIRTH TOE TYPE: [Type]

DECEASED'S BIRTH NAIL TYPE: [Type]

DECEASED'S BIRTH SKIN CARE: [Care]

DECEASED'S BIRTH HAIR CARE: [Care]

DECEASED'S BIRTH EYE CARE: [Care]

DECEASED'S BIRTH MOUTH CARE: [Care]

DECEASED'S BIRTH NOSE CARE: [Care]

DECEASED'S BIRTH EAR CARE: [Care]

DECEASED'S BIRTH FINGER CARE: [Care]

DECEASED'S BIRTH TOE CARE: [Care]

DECEASED'S BIRTH NAIL CARE: [Care]

DECEASED'S BIRTH SKIN HISTORY: [History]

DECEASED'S BIRTH HAIR HISTORY: [History]

DECEASED'S BIRTH EYE HISTORY: [History]

DECEASED'S BIRTH MOUTH HISTORY: [History]

DECEASED'S BIRTH NOSE HISTORY: [History]

DECEASED'S BIRTH EAR HISTORY: [History]

DECEASED'S BIRTH FINGER HISTORY: [History]

DECEASED'S BIRTH TOE HISTORY: [History]

DECEASED'S BIRTH NAIL HISTORY: [History]

DECEASED'S BIRTH SKIN RECORD: [Record]

DECEASED'S BIRTH HAIR RECORD: [Record]

DECEASED'S BIRTH EYE RECORD: [Record]

DECEASED'S BIRTH MOUTH RECORD: [Record]

DECEASED'S BIRTH NOSE RECORD: [Record]

DECEASED'S BIRTH EAR RECORD: [Record]

DECEASED'S BIRTH FINGER RECORD: [Record]

DECEASED'S BIRTH TOE RECORD: [Record]

DECEASED'S BIRTH NAIL RECORD: [Record]

DECEASED'S BIRTH SKIN TREATMENT: [Treatment]

DECEASED'S BIRTH HAIR TREATMENT: [Treatment]

DECEASED'S BIRTH EYE TREATMENT: [Treatment]

DECEASED'S BIRTH MOUTH TREATMENT: [Treatment]

DECEASED'S BIRTH NOSE TREATMENT: [Treatment]

DECEASED'S BIRTH EAR TREATMENT: [Treatment]

DECEASED'S BIRTH FINGER TREATMENT: [Treatment]

DECEASED'S BIRTH TOE TREATMENT: [Treatment]

DECEASED'S BIRTH NAIL TREATMENT: [Treatment]

DECEASED'S BIRTH SKIN PREVENTION: [Prevention]

DECEASED'S BIRTH HAIR PREVENTION: [Prevention]

DECEASED'S BIRTH EYE PREVENTION: [Prevention]

DECEASED'S BIRTH MOUTH PREVENTION: [Prevention]

DECEASED'S BIRTH NOSE PREVENTION: [Prevention]

DECEASED'S BIRTH EAR PREVENTION: [Prevention]

DECEASED'S BIRTH FINGER PREVENTION: [Prevention]

DECEASED'S BIRTH TOE PREVENTION: [Prevention]

DECEASED'S BIRTH NAIL PREVENTION: [Prevention]

DECEASED'S BIRTH SKIN PROTECTION: [Protection]

DECEASED'S BIRTH HAIR PROTECTION: [Protection]

DECEASED'S BIRTH EYE PROTECTION: [Protection]

DECEASED'S BIRTH MOUTH PROTECTION: [Protection]

DECEASED'S BIRTH NOSE PROTECTION: [Protection]

DECEASED'S BIRTH EAR PROTECTION: [Protection]

DECEASED'S BIRTH FINGER PROTECTION: [Protection]

DECEASED'S BIRTH TOE PROTECTION: [Protection]

DECEASED'S BIRTH NAIL PROTECTION: [Protection]

DECEASED'S BIRTH SKIN MAINTENANCE: [Maintenance]

DECEASED'S BIRTH HAIR MAINTENANCE: [Maintenance]

DECEASED'S BIRTH EYE MAINTENANCE: [Maintenance]

DECEASED'S BIRTH MOUTH MAINTENANCE: [Maintenance]

DECEASED'S BIRTH NOSE MAINTENANCE: [Maintenance]

DECEASED'S BIRTH EAR MAINTENANCE: [Maintenance]

DECEASED'S BIRTH FINGER MAINTENANCE: [Maintenance]

DECEASED'S BIRTH TOE MAINTENANCE: [Maintenance]

DECEASED'S BIRTH NAIL MAINTENANCE: [Maintenance]

DECEASED'S BIRTH SKIN HYGIENE: [Hygiene]

DECEASED'S BIRTH HAIR HYGIENE: [Hygiene]

DECEASED'S BIRTH EYE HYGIENE: [Hygiene]

DECEASED'S BIRTH MOUTH HYGIENE: [Hygiene]

DECEASED'S BIRTH NOSE HYGIENE: [Hygiene]

DECEASED'S BIRTH EAR HYGIENE: [Hygiene]

DECEASED'S BIRTH FINGER HYGIENE: [Hygiene]

DECEASED'S BIRTH TOE HYGIENE: [Hygiene]

DECEASED'S BIRTH NAIL HYGIENE: [Hygiene]

DECEASED'S BIRTH SKIN CLEANING: [Cleaning]

DECEASED'S BIRTH HAIR CLEANING: [Cleaning]

DECEASED'S BIRTH EYE CLEANING: [Cleaning]

DECEASED'S BIRTH MOUTH CLEANING: [Cleaning]

DECEASED'S BIRTH NOSE CLEANING: [Cleaning]

DECEASED'S BIRTH EAR CLEANING: [Cleaning]

DECEASED'S BIRTH FINGER CLEANING: [Cleaning]

DECEASED'S BIRTH TOE CLEANING: [Cleaning]

DECEASED'S BIRTH NAIL CLEANING: [Cleaning]

DECEASED'S BIRTH SKIN EXAMINATION: [Examination]

DECEASED'S BIRTH HAIR EXAMINATION: [Examination]

DECEASED'S BIRTH EYE EXAMINATION: [Examination]

DECEASED'S BIRTH MOUTH EXAMINATION: [Examination]

DECEASED'S BIRTH NOSE EXAMINATION: [Examination]

DECEASED'S BIRTH EAR EXAMINATION: [Examination]

DECEASED'S BIRTH FINGER EXAMINATION: [Examination]

DECEASED'S BIRTH TOE EXAMINATION: [Examination]

DECEASED'S BIRTH NAIL EXAMINATION: [Examination]

DECEASED'S BIRTH SKIN TREATMENT HISTORY: [History]

DECEASED'S BIRTH HAIR TREATMENT HISTORY: [History]

DECEASED'S BIRTH EYE TREATMENT HISTORY: [History]

DECEASED'S BIRTH MOUTH TREATMENT HISTORY: [History]

DECEASED'S BIRTH NOSE TREATMENT HISTORY: [History]

DECEASED'S BIRTH EAR TREATMENT HISTORY: [History]

DECEASED'S BIRTH FINGER TREATMENT HISTORY: [History]

DECEASED'S BIRTH TOE TREATMENT HISTORY: [History]

DECEASED'S BIRTH NAIL TREATMENT HISTORY: [History]

DECEASED'S BIRTH SKIN PREVENTION HISTORY: [History]

DECEASED'S BIRTH HAIR PREVENTION HISTORY: [History]

DECEASED'S BIRTH EYE PREVENTION HISTORY: [History]

DECEASED'S BIRTH MOUTH PREVENTION HISTORY: [History]

DECEASED'S BIRTH NOSE PREVENTION HISTORY: [History]

DECEASED'S BIRTH EAR PREVENTION HISTORY: [History]

DECEASED'S BIRTH FINGER PREVENTION HISTORY: [History]

DECEASED'S BIRTH TOE PREVENTION HISTORY: [History]

DECEASED'S BIRTH NAIL PREVENTION HISTORY: [History]

DECEASED'S BIRTH SKIN PROTECTION HISTORY: [History]

DECEASED'S BIRTH HAIR PROTECTION HISTORY: [History]

DECEASED'S BIRTH EYE PROTECTION HISTORY: [History]

DECEASED'S BIRTH MOUTH PROTECTION HISTORY: [History]

DECEASED'S BIRTH NOSE PROTECTION HISTORY: [History]

DECEASED'S BIRTH EAR PROTECTION HISTORY: [History]

DECEASED'S BIRTH FINGER PROTECTION HISTORY: [History]

DECEASED'S BIRTH TOE PROTECTION HISTORY: [History]

DECEASED'S BIRTH NAIL PROTECTION HISTORY: [History]

DECEASED'S BIRTH SKIN MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH HAIR MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH EYE MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH MOUTH MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH NOSE MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH EAR MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH FINGER MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH TOE MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH NAIL MAINTENANCE HISTORY: [History]

DECEASED'S BIRTH SKIN HYGIENE HISTORY: [History]

DECEASED'S BIRTH HAIR HYGIENE HISTORY: [History]

DECEASED'S BIRTH EYE HYGIENE HISTORY: [History]

DECEASED'S BIRTH MOUTH HYGIENE HISTORY: [History]

DECEASED'S BIRTH NOSE HYGIENE HISTORY: [History]

DECEASED'S BIRTH EAR HYGIENE HISTORY: [History]

DECEASED'S BIRTH FINGER HYGIENE HISTORY: [History]

DECEASED'S BIRTH TOE HYGIENE HISTORY: [History]

DECEASED'S BIRTH NAIL HYGIENE HISTORY: [History]

DECEASED'S BIRTH SKIN CLEANING HISTORY: [History]

DECEASED'S BIRTH HAIR CLEANING HISTORY: [History]

DECEASED'S BIRTH EYE CLEANING HISTORY: [History]

DECEASED'S BIRTH MOUTH CLEANING HISTORY: [History]

DECEASED'S BIRTH NOSE CLEANING HISTORY: [History]

DECEASED'S BIRTH EAR CLEANING HISTORY: [History]

DECEASED'S BIRTH FINGER CLEANING HISTORY: [History]

DECEASED'S BIRTH TOE CLEANING HISTORY: [History]

DECEASED'S BIRTH NAIL CLEANING HISTORY: [History]

DECEASED'S BIRTH SKIN EXAMINATION HISTORY: [History]

DECEASED'S BIRTH HAIR EXAMINATION HISTORY: [History]

DECEASED'S BIRTH EYE EXAMINATION HISTORY: [History]

DECEASED'S BIRTH MOUTH EXAMINATION HISTORY: [History]

DECEASED'S BIRTH NOSE EXAMINATION HISTORY: [History]

DECEASED'S BIRTH EAR EXAMINATION HISTORY: [History]

DECEASED'S BIRTH FINGER EXAMINATION HISTORY: [History]

DECEASED'S BIRTH TOE EXAMINATION HISTORY: [History]

DECEASED'S BIRTH NAIL EXAMINATION HISTORY: [History]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10493

10432

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Jay Last Haebel				4. DATE OF DEATH Month September Day 3 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1957		9. AGE (In years lost birthday) 3 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert E. Haebel				14. MOTHER'S MAIDEN NAME Barbara Shellenberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonitis DUE TO Necrotizing Granulomata, of unknown Etiology of Lung, Spleen and Lymph Nodes. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 Hour 2 weeks 3 Years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 29, 1960 to September 3, 1960 , that (I) (we) last saw the deceased alive on September 3, 1960 , and that death occurred on September 3, 1960 at 8:55 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Philip Fireman M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/4/60	
22c. PHYSICIAN'S NAME (Type) PHILIP FIREMAN, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/60		23c. NAME OF CEMETERY OR CREMATORY Kilbide Cemetery		23d. LOCATION (City, town, or county) (State) Roslyn, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Kumpke ADDRESS Bethesda, Md.				25a. REC'D BY REGISTRAR SEP 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Howard	

(M)

(P)

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1943



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard death certificate form with fields for personal information, cause of death, and official certification.]

[Illegible text lines follow, likely containing the deceased's name, date of birth, date of death, and the medical cause of death.]

[Illegible text lines follow, likely containing the names and signatures of the attending physician and the certifying official.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10494

10433

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 4405 38th Street, N.W.	
3. NAME OF DECEASED (Type or print) First Winifred Middle M, Last HANSEN		4. DATE OF DEATH Month September Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-00
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Knud Einarson MO	
14. MOTHER'S MAIDEN NAME Helen GEORGE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 547-46-8379		17. INFORMANT Address (H) Harold D. Hansen, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, colon, with metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 153-8 DUE TO (c) 153-8		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from June 26 12:03AM to Sept. 24 1960 , that he (we) last saw the deceased alive on Sept. 24 1960 , and that death occurred at 12:03AM M, from the causes and on the date stated above.			
22a. SIGNATURE Blair M. Webb		22b. DATE SIGNED 9-24-60	
22c. PHYSICIAN'S NAME (Type) Blair M. WEBB, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9-26-60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey		25a. REC'D BY REGISTRAR DATE SEP 28 1960	
ADDRESS R.A. Humphrey Funeral Home, Bethesda, Md.		25b. REGISTRAR'S SIGNATURE William S. Evans	

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DATE _____ TIME _____

U. S. Navy Historical Center

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall Nursing Home</u>		d. STREET ADDRESS <u>3501 Husted Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Oscar W. Hanson</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 30, 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't Foreman - Pa. Railroad-retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Oscar W. Hanson, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary Boelker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>716-10-3865</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Same as Item #2.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>153.9</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinomatosis</u> c. <u>(Cancer of bowel or liver)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/9</u> , 19 <u>60</u> , to <u>present</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/23</u> , 19 <u>60</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umkon</u>		ADDRESS (Street, city or town, state) <u>8805 Penn. Ave. Altoona, Penna.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umkon</u>		DATE SIGNED <u>9/24/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		22b. DATE THEREOF <u>9-24-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Altoona, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 27 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10495
CERTIFICATE OF DEATH

10435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Etchison		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Etchison	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #### Gaithersburg # 2		d. STREET ADDRESS Gaithersburg Rt. # 2	
3. NAME OF DECEASED (Type or print) First Nettie E. Middle Hawkins Last		4. DATE OF DEATH Month Sept. Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 12, 1868
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Duvall		14. MOTHER'S MAIDEN NAME Jeresha Penn Duvall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
INFORMANT Mr. J. Ernest Hawkins		Address -Etchison, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 23, 1960 to September 27, 1960 that I last saw the deceased alive on September 27, 1960 , and that death occurred at Md. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, state) Damascus, Md.	
DATE SIGNED Sept. 28, 1960		DATE SIGNED Sept. 28, 1960	
PHYSICIAN'S NAME (Type) Dr. James P. Kerr		M.D. Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-30-60	
22c. NAME OF CEMETERY OR CREMATORY Laytonville Meth.		22d. LOCATION (City, town, or county) (State) Laytonville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		ADDRESS Laytonville, Md.	
24a. REC'D BY REGISTRAR OCT 3 '60		24b. REGISTRAR'S SIGNATURE William S. Kraus	

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• **Researcher**

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Dr. J. H. ...

4. *Staph. aureus* 11/10/78.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10496

10436

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Cook		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 33 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 5025 West Ogden Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Head			4. DATE OF DEATH Month September Day 3 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 22, 1934		9. AGE (In years lost birthday) yrs. 26
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman		10b. KIND OF BUSINESS OR INDUSTRY Architectural		11. BIRTHPLACE (State or foreign country) Louisiana	
13. FATHER'S NAME Clarence E. Head			14. MOTHER'S MAIDEN NAME Mary Anna Nail		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1952-1956 558-40-3569		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 204.3 IMMEDIATE CAUSE (a) Pneumonia and pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myelocytic leukemia DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 3 days 1 month					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from August 1, 1960 to September 3, 1960 , that (I) (we) last saw the deceased alive on September 3, 1960 , and that death occurred at 8:30 a.m. from the causes and on the date stated above.					
22a. SIGNATURE Jerome B. Block M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-4-60	
22c. PHYSICIAN'S NAME (Type) Jerome B. Block, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/8/60		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	
23d. LOCATION (City, town, or county) Arlington, Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE SEP 7 '60
			25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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**UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH**

10437

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park, Maryland</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SS Maryland</u> Phone: <u>Pa 7700 X7464</u> d. STREET ADDRESS <u>10600 Lorain Ave. S.S., Md.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry John Herczog</u>			4. DATE OF DEATH Month Day Year <u>September 4 1960</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8/4/20</u>		9. AGE (In years last birthday) <u>40</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Admin - Dept of Defense</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Gov't. U.S.</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio - USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Herczog</u>			14. MOTHER'S MAIDEN NAME <u>Julia Beda</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW2 Army</u>		16. SOCIAL SECURITY NO. <u>295-03-9072</u>		17. INFORMANT Address <u>Wife Mrs. Barbara M. Herczog 10600 Lorain Ave Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>August 27/60</u> to <u>Sept 4, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept 4, 1960</u> and that death occurred on <u>Sept 4</u> PM , from the causes on and on the date stated above.							
22a. SIGNATURE <u>Lysle Williams</u>				22b. DATE SIGNED <u>Sept 5, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lysle Williams</u>				22d. ADDRESS <u>8700 Cleverly Rd, Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/8/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>			
23d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>WYNNE E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.</u> <u>Raymond A. Jiska</u>					
25a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1911

10033

[Faint, mostly illegible text follows, likely containing details of a death certificate such as name, date, and location.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10438

10497

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 311 Farragut St., N.W.	
3. NAME OF DECEASED (Type or print) First Jacquelyn Middle Yvette Last HILL		4. DATE OF DEATH Month September Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-49
9. AGE (In years lost birthday) 10 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 10 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. HILL		14. MOTHER'S MAIDEN NAME Eva SAPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address (M) Mrs. Eva Hill, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 193.9 DUE TO Glioblastoma multiforme Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) person attended the deceased from Sept. 9 19 60 , to Sept. 26 19 60 , that (I) was last saw the deceased alive on Sept. 26 19 60 , and that death occurred at 2:40AM , from the causes and on the date stated above.			
22a. SIGNATURE W. H. Druckemiller M.D.		22b. DATE SIGNED 9-26-60	
22c. PHYSICIAN'S NAME (Type) W. H. DRUCKEMILLER, CAPT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/3/1960	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis ADDRESS 1432 "U" St., NW, Washington, DC		25a. REC'D BY REGISTRAR DATE SEP 28 '60	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

10497

CERTIFICATE OF DEATH

State of Colorado

Washington

17 days

Barbours (Mrs.)

U. S. Naval Hospital

311 Twenty 2nd, N.W.

September 22

1917

Yvonne

Josephine

10

10-20-17

Wanda

Wanda

U.S.A.

Illinois

1917

born in 1917

(N) Mrs. and Bill, born in 1917 above

Illinois

Sept. 2 1917

2:40 AM

Sept. 20 1917

9-20-17

U. S. Naval Hospital, Bethesda, Md.

Virginia

Washington

Washington National

Bethesda

W. S. Davis, 1917, Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10439

10498

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN Tb 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS Route #2			
3. NAME OF DECEASED (Type or print) First Walter Middle Miller Last Hill				4. DATE OF DEATH Month Sept. Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/11	
9. AGE (in years lost (thday) yrs.) 48		IF UNDER 1 YEAR Months 48 Days 48 Hours 48 Min. 48		IF UNDER 24 HRS. Months 48 Days 48 Hours 48 Min. 48			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Salesman				10b. KIND OF BUSINESS OR INDUSTRY Cave Ford		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter Hill				14. MOTHER'S MAIDEN NAME Bertie Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-03-8245			
17. INFORMANT Mother, Mrs. Bertie Hill LePron				Address Baltimore Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute posterior myocardial infarction DUE TO 8 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO 10 days (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept. 11, 1960 to Sept. 14, 1960 , that (I) (we) lost the deceased alive on Sept. 14, 1960 , and that death occurred at 3 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Robert N. Coale M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Sept. 14, 1960							
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE 22d. ADDRESS 4630 Montgomery Ave., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 17, 1960 23c. NAME OF CEMETERY OR CREMATORY Laytonsville Meth. Laytonsville, Md. 23d. LOCATION (City, town, or county) (State)							
24. FUNERAL DIRECTOR'S SIGNATURE Francis K. Barber ADDRESS Laytonsville, Md. 25a. REC'D BY REGISTRAR SEP 19 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Hume							

CERTIFICATE OF DEATH

1943

(1)

NAME OF DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

DECEASED
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
AGE
SEX
RACE
RELIGION
EDUCATION
OCCUPATION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

10499

CERTIFICATE OF DEATH

10440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Albans Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
c. LENGTH OF STAY IN 1b <u>30 days</u>		d. STREET ADDRESS <u>1102-10th St. S.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Everest Care Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN FRANCIS HOFFMAN</u>		4. DATE OF DEATH Month Day Year <u>9 - 19 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4-11-07</u>
9. AGE (In years last birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labourer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Single County Club</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas E. Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Annie A. Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>57530-7369</u>	
17. INFORMANT <u>George H. Hoffman</u>		Address <u>1102-10th St. S.E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus a metastasis</u> DUE TO <u>150X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 18</u> , 19 <u>60</u> , to <u>Sept 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 18</u> , 19 <u>60</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. D. Bonifant</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>	
DATE SIGNED <u>9/19/60</u>			
PHYSICIAN'S NAME (Type) <u>DERMENT A. BONIFANT</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-22-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington Mt. Cm.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chamber L. Inc.</u>		ADDRESS <u>517-11th St. S.E.</u>	
24a. REC'D BY REGISTRAR <u>SEP 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



100

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10500

Item 9 011052/2 10-3-60 et

CERTIFICATE OF DEATH

10441

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS Box 13		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bradford Middle Burnside Last Hopkins				4. DATE OF DEATH Month Sept. Day 22 Year 19 60			
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/26/07		9. AGE (In years last birthday) 52 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Manual Labor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank Francis Hopkins				14. MOTHER'S MAIDEN NAME Annie Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown.		17. INFORMANT Dora Hopkins		Address Sandy Spring, Md. Box 13	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral edema DUE TO 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right lateral ventricular hemorrhage DUE TO 2 days (c) Hypertensive Cardiovascular Renal disease Years						INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____, to Sept. 21, 1960 that (I) (we) last saw the deceased alive on Sept. 21, 1960 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE G. Bowditch Hunter, Jr.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Sept. 22, 1960	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-24-60		23c. NAME OF CEMETERY OR CREMATORY Sandy Spring,		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Shaver				ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE Gordon L. Hunter	
				25a. REC'D BY REGISTRAR DATE SEP 26 '60			

MEDICAL CERTIFICATION

2

1

074

1

MI

VERIFICATE OF DEATH

1934



[Faint, mostly illegible text and lines on a form, likely containing personal and medical details.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10442

10420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> 23	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium</i>		d. STREET ADDRESS <i>113 Croydon Court</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Vanessa</i> Middle <i>Lynn</i> Last <i>Huebner</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8:48 PM</i> Sept. 11, 1960
9. AGE (In years lost birthday) yrs. <i>22</i>		10. IF UNDER 1 YEAR Months <i>-</i> Days <i>-</i> Hours <i>-</i> Min. <i>-</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Adrian S Huebner</i>		14. MOTHER'S MAIDEN NAME <i>Shirley Stewart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mother</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>24 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 11</i> , 1960, to <i>Sept 12</i> , 1960, that I last saw the deceased alive on <i>Sept 12</i> , 1960, and that death occurred at <i>6:30 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Hyman Colvin</i>		ADDRESS (Street, city or town, state) <i>1211 Sheridan St. Wash. D.C.</i> DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Hyman Colvin MD</i>		<i>1211 Sheridan St., N.W. Wash. D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>9-12-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Washington Sanitarium and Hospital, Takoma Park, Md.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Hare, M. D. Washington Sanitarium and Hospital, Takoma Park, Maryland</i>		24a. REC'D BY REGISTRAR <i>SEP 14 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hare</i>	

2075192XV2

CERTIFICATE OF DEATH

Reg. Dist. No.

10443

10457

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 ROCKVILLE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13005 PARKLAND DRIVE				d. STREET ADDRESS 1 13005 PARKLAND DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Jr Last Hughes				4. DATE OF DEATH Month 9 Day 14 Year 1960			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-30-23	
9. AGE (In years last birthday) 37 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinest		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS M. HUGHES				14. MOTHER'S MAIDEN NAME LUCY A. THOMAS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT THOMAS M. HUGHES (Same as 2d)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal Hemorrhage 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Wernia (c) Chronic glomerulonephritis						INTERVAL BETWEEN ONSET AND DEATH 30 min. 1 yr. 22 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 1, 1953 to 9/14/1960 that I last saw the deceased alive on 9/14/1960 , and that death occurred at 6:50 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stephen N. Jones		M.D. Rockville, Md		ADDRESS (Street, city or town, state) Rockville, Md		DATE SIGNED 9/14/60	
PHYSICIAN'S NAME (Type) STEPHEN N. JONES		M. D. M. D.		CITY OR TOWN ROCKVILLE		STATE MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-16-60		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM.		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins				ADDRESS WASH. D.C.		24a. REC'D BY REGISTRAR SEP 16 '60	
23. FUNERAL DIRECTOR'S SIGNATURE FRANCIS J. COLLINS				ADDRESS 3821 14th St. N.W.		24b. REGISTRAR'S SIGNATURE Charles S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10433

MONTGOMERY

WINDLAND

MONTGOMERY

WINDLAND

1200 WINDLAND DRIVE

1200 WINDLAND DRIVE

WINDLAND

WINDLAND

U.S. DEPT. OF HEALTH

U.S. DEPT. OF HEALTH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10501

CERTIFICATE OF DEATH

10444

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 14300 Lay Hill Rd.	
3. NAME OF DECEASED (Type or print) Norman Lawrence HULL		4. DATE OF DEATH Sept. 21 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1890
9. AGE (In years 70 months 10 days 10 hours 10 min.)		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret.) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hull		14. MOTHER'S MAIDEN NAME Sarah Roberts	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Mrs. Preston Hull		Address 1500 Atwood Rd SS Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Congestive heart failure DUE TO (b) Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) diabetes & cirrhosis liver		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/55 to 9/21/60 , that (I) (we) last saw the deceased alive on 9/20 19 60 , and that death occurred at 645M , from the causes and on the date stated above.			
22a. SIGNATURE Patrick C. Jamieson M.D.		22b. DATE SIGNED 9/21/60	
22c. PHYSICIAN'S NAME (Type) PATRICK C. JAMIESON		22d. ADDRESS 12020 Heavens Silver Spring Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/23/60	
23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE SEP 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10445

Reg. Dist. No.

<p style="font-size: 1.5em; margin: 0;">10502</p>							
<p>1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery</p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seneca</p>			<p>c. LENGTH OF STAY IN lb 3 hours</p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Bethesda</p>		
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>				<p>d. STREET ADDRESS 8601 Irvington Avenue</p>			<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>
<p>3. NAME OF DECEASED (Type or print) First Thomas Middle L. Last Jackson</p>				<p>4. DATE OF DEATH Month September Day 12 Year 19 60</p>			
<p>5. SEX Male</p>	<p>6. COLOR OR RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH April 21, 1901</p>		<p>9. AGE (In years last birthday) 59 yrs.</p>	<p>IF UNDER 1 YEAR Months 59 Days 0 Hours 0 Min. 0</p>	<p>IF UNDER 24 HRS. Hours 0 Min. 0</p>
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lt. Com. MSC ret.</p>			<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) West Virginia</p>		<p>12. CITIZEN OF WHAT COUNTRY? US</p>
<p>13. FATHER'S NAME Thomas Jackson</p>				<p>14. MOTHER'S MAIDEN NAME Bertha ?</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes</p>		<p>16. SOCIAL SECURITY NO. WW 1</p>		<p>17. INFORMANT Margaret Jackson-wife-same 2d</p>			<p>Address</p>
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ (c) _____</p>							<p>INTERVAL BETWEEN ONSET AND DEATH sudden</p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____</p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____</p>	<p>Month, Day, Year 19</p>	<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	<p>20f. (City or town)</p>	<p>(County)</p>	<p>(State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p>							
<p>ACTUAL SIGNATURE <i>Frank J. Broschart</i></p>				<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>		<p>DATE SIGNED</p>	
<p>EXAMINER'S NAME (Type) Frank J. Broschart</p>				<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>		<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF 9/14/60</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.</p>		<p>22d. LOCATION (City, town, or county) (State) Arlington, Virginia</p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey</p>				<p>ADDRESS Bethesda, Maryland</p>		<p>24a. REC'D BY REGISTRAR SEP 14 '60</p>	<p>24b. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i></p>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a portion of the certificate is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12-1-19

NAME OF DECEASED JAMES J. JONES		SEX Male		AGE 34 Years		RACE White	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk		MARITAL STATUS Single		RELIGION Catholic	
STREET ADDRESS 1001 LEVINGTON AVENUE		CITY Baltimore		STATE Md.		COUNTY Baltimore	
DATE OF DEATH December 1, 1918		TIME OF DEATH 10:30 A.M.		PLACE OF DEATH Home		CAUSE OF DEATH Pneumonia	
MEDICAL HISTORY Patient had been ill for several days with fever and cough.		PRESENT ILLNESS Onset of illness on November 25, 1918.		POST-MORTEM EXAMINATION Not performed.		TOXICOLOGICAL EXAMINATION Not performed.	
SIGNATURE OF PHYSICIAN J. J. Jones		SIGNATURE OF MEDICAL EXAMINER J. J. Jones		SIGNATURE OF CORONER J. J. Jones		SIGNATURE OF JURY J. J. Jones	
DATE 12/1/18		TIME 10:30 A.M.		PLACE Home		COUNTY Baltimore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10448

10446

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens SAN.		d. STREET ADDRESS 4012 Virgilia Street	
3. NAME OF DECEASED (Type or print) First Jannie Middle May Last Jacobs		4. DATE OF DEATH Month September Day 9 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1870
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henny Chase		14. MOTHER'S MAIDEN NAME Ella Tucker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. J.W. Stover		Address 7616 Conn. Ave. N.W. Ch. 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Respiratory xxx Failure DUE TO (c) Hyperpyrexia		INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 48 hrs. 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sep 2 1960 to Sep 9 1960 , that (I) (we) last saw the deceased alive on Sep 6 1960 , and that death occurred at 7:00p from the causes and on the date stated above.		22a. SIGNATURE Robert T. Thibadeau M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE September 9, 1960	
22c. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.		22d. ADDRESS 10609 Concord St., Kensington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/60	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR SEP 14 '60 25b. REGISTRAR'S SIGNATURE Arthur L. Howard	

(M)

1044

CERTIFICATE OF DEATH

REGISTERED

DEATH

JOHN ALBERT

JOHN ALBERT

JOHN ALBERT

JOHN ALBERT

JOHN ALBERT

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JOHN ALBERT

JOHN ALBERT

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10435 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10447

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
c. LENGTH OF STAY IN lb <u>43 yrs</u>				d. STREET ADDRESS <u>4807 Dorset Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4807 Dorset Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Bella</u>		First <u>Jaffe</u> Middle Last		4. DATE OF DEATH <u>Sept 4</u>		Month <u>1960</u> Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-1879</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Abraham Laddon</u>				14. MOTHER'S MAIDEN NAME <u>Bertha</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Victor Jaffe</u>				Address <u>3621 Appleton St N.W. Wash D.C.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>420.1</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of fusion heart disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>9-4-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Hebrew Cong. Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Washington - D.C.</u>	
23. FUNERAL DIRECTOR <u>B. Danzansky</u>				24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>			
ADDRESS <u>1505-3501-14th St. N.W.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH
M

Attest my hand and seal of office this 1st day of May 1900.

John T. [Signature]

1

John T. [Signature]

1-10-00

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10448

10503

Item 1c Film G271 9-23-60 et

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY 77X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pelzer d. STREET ADDRESS 11 Green Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herbert William Janssen		4. DATE OF DEATH Month Day Year September 19, 1960	
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH January 13, 1930
9. AGE (In years lost birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) T/Sgt. U.S. Air Force		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Carl Janssen		14. MOTHER'S MAIDEN NAME Tillie Kuper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Present		16. SOCIAL SECURITY NO. Unavailable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, pulmonary edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignant lymphoma, widely disseminated to lymph nodes, abdominal thoracic viscera and skin DUE TO (c) Hyperparathyroidism		INTERVAL BETWEEN ONSET AND DEATH days months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hyperparathyroidism		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 26, 1960 to September 19, 1960 that (I) (we) last saw the deceased alive on September 19, 1960 and that death occurred at 5:50 PM from the causes and on the date stated above.			
22a. SIGNATURE Jerome B. Block		22b. DATE SIGNED September 20, 1960	
22c. PHYSICIAN'S NAME (Type) Jerome B. Block, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF SEPT. 23 1960	
23c. NAME OF CEMETERY OR CREMATORY Russell Funeral Home, 816 N. St. N.E., DC 2		23d. LOCATION (City, town, or county) (State) PELZER S.C. Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Russell Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 23 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1932

M

Name of Deceased

Age

Sex

Color

Place of Birth

Date of Death

Time of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Minister

Date

Place

Signature of

Signature of

Signature of

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10421

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7121 Willow Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>P.</u> Last <u>JESTER</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hearing Aid Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hearing Aid</u>	11. BIRTHPLACE (State or foreign country) <u>Talbot Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James A. Jester</u>	
14. MOTHER'S MAIDEN NAME <u>Ida B. Judd</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>579-03-7406</u>		17. INFORMANT <u>Mrs. Marian S. Jester</u> Address <u>(Same as #2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senile Arteriosclerosis Generalized.</u> DUE TO (c) <u>Arrested Tuberculosis of Lungs.</u> 002X			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>2 weeks</u> <u>5-6 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept.</u> 1956, to <u>19 Sept.</u> 1960, that I last saw the deceased alive on <u>19 Sept.</u> 1960, and that death occurred at <u>8:30 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. B. Queen</u>		ADDRESS (Street, city or town, state) <u>7112 Willow Ave.</u> DATE SIGNED <u>19 Sept 1960</u>	
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN M.D.</u>		<u>TAKOMA PARK MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 22, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll N.W. LOC</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10431

MASSACHUSETTS

DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS

MASSACHUSETTS

1. FULL NAME OF DECEASED

LAST NAME

FIRST NAME

MIDDLE NAME

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

DATE OF RECREMATION

PLACE OF RECREMATION

DATE OF REEXHUMATION

PLACE OF REEXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REBURIAL

PLACE OF REBURIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10422

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10450

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		d. STREET ADDRESS <u>7301 23rd Ave Lewisdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Dewey</u> Last <u>Johns</u>		4. DATE OF DEATH Month <u>9</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-99</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>Charles Johns</u>		14. MOTHER'S MAIDEN NAME <u>Ione Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT Address <u>Takoma Park Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute hemorrhagic Pancreatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>587.0</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 17</u> 19 <u>60</u> , to <u>Sept 22</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sept 22</u> 19 <u>60</u> , and that death occurred at <u>4:25</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>H. Wayne Blackfield</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>H. Wayne Blackfield MD</u>		22d. ADDRESS <u>6826 Piggys Rd Hyattville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-26-60</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Arle Nat Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Arle Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 26 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>		25c. ADDRESS <u>300 4th St. N.E. D.C.</u>	

10/10

CERTIFICATE OF DESIGN

11/11

(M)

(1)

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont	c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Little Falls - Potomac River		d. STREET ADDRESS 1310 N. Courthouse Road	
3. NAME OF DECEASED (Type or print) First IRELAND Middle JOHNSON Last JOHNSON		4. DATE OF DEATH Month Sept Day 18 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 20 Jan 1928
9. AGE (In years last birthday) 32 yrs.		10. IF UNDER 1 YEAR Months 32 Days 32 Hours 32 Min.	11. IF UNDER 24 HRS. Months 32 Days 32 Hours 32 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sgt. - US Army		10b. KIND OF BUSINESS OR INDUSTRY Soldier	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clyde Johnson		14. MOTHER'S MAIDEN NAME Mina Harvey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. active duty 234-42-3365	
17. INFORMANT Emma Johnson - Arlington, Virginia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat over turned going over falls	
20c. TIME OF INJURY Hour 7:00 p. m. Month, Day, Year 9/18 19 60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River	20f. (City or town) (County) (State) Brookmont, Montgomery, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 9/20/60	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) SEPT. 23 1960 BURIAL	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL	22d. LOCATION (City, town, or county) (State) ARLINGTON VA.
23. FUNERAL DIRECTOR'S SIGNATURE RINALDI FUNERAL HOME 86 HST. NE DC 2		24a. REC'D BY REGISTRAR DATE SEP 23 '60	24b. REGISTRAR'S SIGNATURE Carlton P. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

(K)

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1934

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH -

AGE

SEX

DATE

PLACE

TIME

AND VITALITY

EDUCATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10452

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		d. STREET ADDRESS 3700 Mass Ave, NW 47X-3	
3. NAME OF DECEASED (Type or print) First MILDRED Middle TABB Last JOHNSON		4. DATE OF DEATH Month September Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-05
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Warner Lewis Tabb		14. MOTHER'S MAIDEN NAME Minnie Weedon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		17. INFORMANT Richard F.J. Johnson Jr. Address Washington DC	
16. SOCIAL SECURITY NO. None		3700 Mass Ave NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-16 1960 , to 9-4 1960 , that (I) (we) last saw the deceased alive on 9-4 1960 , and that death occurred at 6:40 AM from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED 9-4-60	
22c. PHYSICIAN'S NAME (Type or print) L.J. HINES, CDR MC USN		22d. ADDRESS U.S. NAVAL HOSPITAL, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-8-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Grawler & Sons ADDRESS 1756 Penn. Ave. NW Washington, DC		25a. REC'D BY REGISTRAR DATE SEP 9 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CERTIFICATE OF DEATH

10514

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DATE OF DEATH

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PLACE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10453

10506

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>9 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lancaster</u> 75X-3 d. STREET ADDRESS <u>48 S. Water Street</u>											
3. NAME OF DECEASED (Type or print) First <u>Janie</u> Middle <u>Marie</u> Last <u>JUMBELICK</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>9</u> Year <u>1960</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-34</u>		9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Rosser CALVIN</u>						14. MOTHER'S MAIDEN NAME <u>Bazzle TRACY</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>228-38-3273</u>				17. INFORMANT <u>Hospital records</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 4-14X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Initial Stenosis and Insufficiency</u> DUE TO (c) <u>Rheumatic valvulitis</u>												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>9-1-</u> <u>1960</u> to <u>9-9-</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>9-9-</u> <u>1960</u> , and that death occurred at <u>10:08PM</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Robert C. Thomas</u> M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>9-10-60</u>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Robert C. THOMAS, LT, MC, USN</u>						22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9-10-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Transit</u>				23d. LOCATION (City, town, or county) (State) <u>Lancaster County, Penna.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>R.A. Pumphrey</u> ADDRESS <u>7557 Wisconsin Ave., Bethesda, Md.</u>						25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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• *Journal of the American Medical Association*, 1997; 277: 1000-1005

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10507

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film 6273 10-20-60 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland D.C. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15½ days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington Washington 47X3	
f. STREET ADDRESS 5425 Conn. Ave. N.W. LeDeau Gardens Nursing Home		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bertha Younger Keller		4. DATE OF DEATH Month 9 Day 6 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/25/1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 5	IF UNDER 24 HRS. Hours 19 Min. 60
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired PBX Operator Telephone		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Younger		14. MOTHER'S MAIDEN NAME Virginia Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-44-8125 yes	
17. INFORMANT Mrs. Marjorie G. Matthews, 11,905 Dalewood Dr. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO 2nd & 3rd degree burns involving neck, chest & arms Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 15½ days DUE TO (c) 15½ days		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Clothes caught afire while lighting cigarette with lighter	
20c. TIME OF INJURY Hour 5:30 p. m. 8/21/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home		20f. (City or town) Kensington (County) Montg (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 9/6/60	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/9/60	
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE SEP 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Haines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED
STATE HEALTH DEPARTMENT
BALTIMORE, MARYLAND
JAN 10 1910

10007

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: John Smith

AGE: 45 YEARS

SEX: Male

DATE OF DEATH: Jan 10 1910

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

IMMEDIATE CAUSE: Myocardial Infarction

PREVAILING DISEASE: Coronary Artery Disease

DATE OF EXAMINATION: Jan 10 1910

SIGNATURE OF EXAMINER: Dr. J. H. Smith

OFFICE OF EXAMINER: Baltimore, Md.

DATE OF REPORT: Jan 10 1910

REPORT TO: State Health Department

REMARKS: Deceased was found dead in bed, no signs of life. Heart was enlarged and showed signs of infarction.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/59

10508

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10456

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
c. LENGTH OF STAY IN 1b 239 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 3403 University Boulevard, Apt. F6	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harris Middle Jackson Last Kirkland, Jr.		4. DATE OF DEATH Month September Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1955
9. AGE (In years lost birthday) 5 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harris J. Kirkland, Sr.		14. MOTHER'S MAIDEN NAME Edna M. Temples	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding diathesis DUE TO (b) Thrombocytopenia months DUE TO (c) Acute lymphocytic leukemia 2 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (♣) (this hospital) attended the deceased from January 15, 19 60 to September 10, 19 60 that (♣) (we) lost saw the deceased alive and September 10, 19 60 , and that death occurred on 7:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Haskins K. Kashima M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 9/11/60 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Haskins K. Kashima, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, or MOV. (State) SHIP RR.		23b. DATE THEREOF 9-12-60	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) MULBERRY FLA.	
24. FUNERAL DIRECTOR'S SIGNATURE CHAMBERS FUNERAL HOME ADDRESS 1400 CHAPMAN ST. WASH, D.C.		25a. REC'D BY REGISTRAR SEP 19 '60 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

1006

STATE OF TEXAS

County of _____

Know all men by these presents, _____

do hereby certify that _____

10402

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10457

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>8 MONTHS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>2805 PARKER AVENUE</u>				d. STREET ADDRESS <u>12805 PARKER AVENUE</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ELIZABETH KURTZ</u>				4. DATE OF DEATH Month Day Year <u>SEPT. 17 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>JUNE 13, 1916</u>		9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE - Own Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>DAVID HUMBERSON</u>			
14. MOTHER'S MAIDEN NAME <u>LONA FRIEND</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>218-20-1736</u>		17. INFORMANT Address <u>ANDREW A. KURTZ (HUSBAND) SAME</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RHEUMATIC HEART DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>10 MINUTES</u> <u>20 YRS.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1960</u> to <u>SEPT. 17, 1960</u> that (I) (we) last saw the deceased alive on <u>AUG. 24, 1960</u> and that death occurred at <u>3 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Belden R. Reap</u>				22b. DATE SIGNED <u>9/17/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP</u>				22d. ADDRESS <u>11502 GRANDVIEW AVE, WHEATON MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 21, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bloomingrose Methodist Church Cem., Friendsville, Garrett, Md.</u>			
23d. LOCATION (City, town, or county) (State) _____							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>DATE SEP 21 '60</u>			
ADDRESS <u>Silver Spring, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

10458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Montana b. COUNTY Cascade	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Falls	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 2722 North 6th Avenue	
3. NAME OF DECEASED (Type or print) First Melvin Robert Middle Lager Last Lager		4. DATE OF DEATH Month September Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 25, 1924
9. AGE (In years last birthday) 35 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Carl A. Lager		14. MOTHER'S MAIDEN NAME Inga A. Larsen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 516-22-1088	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laceration in aorta DUE TO (c) Patent ductus arteriosus		INTERVAL BETWEEN ONSET AND DEATH approximately 1 hour 2 hours Congenital	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 13, 1960 to September 21, 1960 , that I last saw the deceased alive on September 21, 1960 , and that death occurred at 1:46 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Roland Folse		DATE SIGNED 9/22/60	
PHYSICIAN'S NAME (Type) Roland Folse, M.D.		ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-22-60		22b. DATE THEREOF 9-22-60	
22c. NAME OF CEMETERY OR CREMATORY Hill County Cemetery		22d. LOCATION (City, town, or county) (State) Hill County, Montana	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		24a. REC'D BY REGISTRAR DATE SEP 23 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM A. BISHOP, JR.,

9-22-50, 1111 1/2 Street, N.W., Washington, D.C.

WILLIAM A. BISHOP, JR.,

1111 1/2 Street, N.W., Washington, D.C.

WASHINGTON, D.C.

1111 1/2 Street, N.W., Washington, D.C.

1111 1/2 Street, N.W., Washington, D.C.

1111 1/2 Street, N.W., Washington, D.C.

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1111 1/2 Street, N.W., Washington, D.C.

1111 1/2 Street, N.W., Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookmont		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Little Falls - Potomac River		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond Lee LAMBERT		4. DATE OF DEATH Month Day Year September 18 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1941
9. AGE (In years last birthday) yrs. 19		10. IF UNDER 1 YEAR Months 7 Days 9	
11. IF UNDER 24 HRS. Hours 7 Min. 19		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jessie Lambert		14. MOTHER'S MAIDEN NAME Christine Stratton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-60-9425	
17. INFORMANT Address Montg. Co. Police Records-Bethesda Station			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat overturned going over falls	
20c. TIME OF INJURY Month, Day, Year 7:00 p.m. 9/18 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac River		20f. (City or town) (County) (State) Brookmont Montgomery Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED September 21, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 9/24/60	
22c. NAME OF CEMETERY OR CREMATORY Lambert Cemetery		22d. LOCATION (City, town, or county) (State) Fry, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 23 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

10511

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jersey City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS 208 South Street 67X-3	
3. NAME OF DECEASED (Type or print) First Middle Last Carole Ann Lane		4. DATE OF DEATH Month Day Year September 20 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1936
9. AGE (In years lost birthday) 23 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 10 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Frank Calnan		14. MOTHER'S MAIDEN NAME Vera Giovannitti	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia and arrest 410X DUE TO Rheumatic Heart disease with mitral stenosis and insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 hours years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 5, 19 60 , to September 20, 19 60 , that I last saw the deceased alive on September 20, 19 60 , and that death occurred at 12:25 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Talbert		DATE SIGNED 9/20/60	
PHYSICIAN'S NAME (Type) James L. Talbert, M.D.		M.D. The Clinical Center, National	
Institutes of Health, Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Bur-transit	9/21/60	Flower Hill Cemetery	Bergen New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE SEP 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1951

CERTIFICATE OF DEATH

Robert A. Murphy

Bethesda

The National Center

Office

Washington, D.C.

Residence

1100

Unknown

Cardiac arrhythmia and arrest

Heart disease with infarction

and infarction

Handwritten signature

James A. Taylor, M.D.

Dr. James A. Taylor, M.D.

Robert A. Murphy, Bethesda, Maryland

Flower Hill Cemetery

Bethesda

New Jersey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, or any event, within 72 hours after death.

VR A15 (4)
15M 9/59

10512

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10461

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights d. STREET ADDRESS 434 Quade Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Manuel Last LANHAM		4. DATE OF DEATH Month September Day 22 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-29-20
9. AGE (In years lost birthday) 40 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Rufus L. LANHAM	
14. MOTHER'S MAIDEN NAME Dettie E. MANUEL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 1939 to 1958		17. INFORMANT 400-18-8222 (W) Mrs. Marion R. Lanham, same as #2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, bile duct & metastasis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastasis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (physician) attended the deceased from Sept. 8 , 19 60 , to Sept. 22 , 19 60 , that (I) (physician) saw the deceased alive on Sept. 22 , 19 60 , and that death occurred at 9:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE W. D. Hooper		22b. DATE SIGNED 9-22-60	
22c. PHYSICIAN'S NAME (Type) W. D. HOOVER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		25a. REC'D BY REGISTRAR DATE SEP 26 '60	
ADDRESS 1661 Good Hope Rd, SE, WashDC		25b. REGISTRAR'S SIGNATURE Charles L. Hume	

STATE OF TEXAS
COUNTY OF DALLAS
CERTIFICATE OF DEATH

1911

(M)

Deceased

Married

Age

Profession

Residence (Home)

13 days

Present Address

U. S. Naval Hospital

434 1/2 Main Street

Robert

Married

John

Residence 12

Male

Occupation

3-29-30

43

Married

U. S. Navy

Married

U. S. Navy

John J. LAMAR

David A. LAMAR

For

1911 to 1912

400-10-222 (M)

John J. LAMAR, born on 12 days

(1)

1911

1911

1911

1911

U. S. Naval Hospital, Houston, TX

U. S. Naval Hospital, Houston, TX

American National

American National

American National

1911 to 1912, 400-10-222 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
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10513

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10462

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 40 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Edwin Last LATIMER		4. DATE OF DEATH Month September Day 16 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH 5-11-02
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months 3 Days 2 Hours 0 Min. 0	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		11b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	
12. BIRTHPLACE (State or foreign country) District of Columbia		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Clarence E. LATIMER		15. MOTHER'S MAIDEN NAME Elisabeth SMITH	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		17. SOCIAL SECURITY NO. 1924 to 1953	
18. INFORMANT Mary K. LATIMER		19. ADDRESS 805 Chalfonte Dr., Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tumor, carcinoma, metastatic DUE TO 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) " Lung " DUE TO " " (c) Coronary kidney, primary		INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-7-60 to 9-16 , 19 60 , that (I) (we) last saw the deceased alive on 9-16 , 19 60 , and that death occurred at 4:50 PM from the causes and on the date stated above.			
22a. SIGNATURE F. H. O'CONNELL		22b. DATE SIGNED 9/17/60	
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN		22d. ADDRESS U. S. NAVAL HOSPITAL, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-20-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawlers's & Sons		25a. REC'D BY REGISTRAR SEP 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

UNITED STATES OF AMERICA

10513

Government (Civil) No. 10513 U. S. District Court

Plaintiff Defendant Cause No. 10513

U. S. District Court U. S. District Court U. S. District Court

U. S. District Court U. S. District Court U. S. District Court

U. S. District Court U. S. District Court U. S. District Court

U. S. District Court U. S. District Court U. S. District Court

U. S. District Court U. S. District Court U. S. District Court

U. S. District Court U. S. District Court U. S. District Court

U. S. District Court U. S. District Court U. S. District Court

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10514

CERTIFICATE OF DEATH

10463

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>47X3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORBECK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. PHILomena's Rest Home</u>		d. STREET ADDRESS <u>1621 Irving St N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>T</u> Last <u>Leddy</u>		4. DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 19, 1882</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John P. Leddy</u>		14. MOTHER'S MAIDEN NAME <u>Helen HEALY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNAVAILABLE</u>	
17. INFORMANT Address <u>MRS AGATHA JONES 112 2nd St N.E.W.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>20 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 5, 1960</u> to <u>Sept 25, 1960</u> , that I last saw the deceased alive on <u>9-19, 1960</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry J. Kicheter</u> M.D. <u>5527 Surrey St.</u>		DATE SIGNED <u>9/25/60</u>	
PHYSICIAN'S NAME (Type) <u>H. J. Kicheter</u>		<u>Chevy Chase, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>Sept 27, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. DC.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm T. Atwell</u> ADDRESS <u>3603 14th St NW</u>		24a. REG'D BY REGISTRAR DATE <u>SEP 27 1960</u>	
		24b. REGISTRAR'S SIGNATURE <u>Ernest B. Kinsell</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10464

CERTIFICATE OF DEATH

10449

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>421 Buchanan St. NW Wash D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>				d. STREET ADDRESS <u>3000 McComas Ave. 47 X 3</u>			
3. NAME OF DECEASED (Type or print) First <u>Lula</u> Middle <u>E.</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 8, 1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Chas. E. Winstead</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Dungan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Wilbert C. Lewis 509 Somerset Pl. Chillum</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma</u> DUE TO (b) <u>1960-9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>3:05</u> Hour, <u>9</u> Day, <u>2</u> Year, <u>1960</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u>Silver Spring, Md.</u>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 7, 1960</u> to <u>SEPT. 2, 1960</u> , that (I) (we) last saw the deceased alive on <u>AUG. 27, 1960</u> , and that death occurred at <u>3:05</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>G. Fennard</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 2, 1960</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <u>8641 Cokesville Rd. Silver Spr., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9-6-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u>				ADDRESS <u>4812 Ga Ave NW</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fenn</u>	

CERTIFICATE OF DEATH

10443

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10465

10423

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>47 X-3</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>6633 Barnaby st. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FREDERICK C. LINCOLN</u> First Middle Last			4. DATE OF DEATH <u>Sep. 16, 1960</u> Month Day Year				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>5-5-92</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Biologist</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Colorado</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Fred Lincoln</u>			
14. MOTHER'S MAIDEN NAME <u>Ina Nitschke</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> DUE TO (b) <u>CONGESTIVE HEART DISEASE</u> DUE TO (c) <u>HEART BLOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASPIRATION OF GASTRIC CONTENT</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1960</u> to <u>Sept. 16, 1960</u> that (I) (we) last saw the deceased alive on <u>Sept. 16, 1960</u> and that death occurred at <u>7:20 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Lynwood Helges</u>				22b. DATE SIGNED <u>9/16/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lynwood Helges</u>				22d. ADDRESS <u>6940 Piney Branch R., N.W., Wash, D.C.</u>			
23a. BURIAL, CREMATION, etc. <u>Cremation</u>		23b. DATE THEREOF <u>9/20/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>			
23d. LOCATION (City, town, or county) <u>Pr. Geo. Co., Maryland</u>		(State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W., Wash, DC</u>			
25a. REC'D BY REGISTRAR <u>SEP 20 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

100-100



THE REGISTRAR GENERAL OF BIRTHS, DEATHS AND MARRIAGES,
NEW ZEALAND.

I hereby certify that on the _____ day of _____ 19____
at _____ in the _____ District of _____
New Zealand, _____
aged _____ years,
of the _____
_____ (Name of Deceased)
died of _____
(Cause of Death)
as certified by the _____
(Medical Officer of Health)
and as recorded by me, the Registrar General.

Signed _____
(Registrar General)

Witness my hand and seal this _____ day of _____ 19____.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8, 9, 11 Film 6271 9-23-60 et

10515

10466

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 110 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 149 Ritchie Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude XXXXX		4. DATE OF DEATH Month Day Year September 20 19 60	
5. SEX Female		6. COLOR OR RACE Caucasian	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-3-77 1877	
9. AGE (In years last birthday) 84 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11c. BIRTHPLACE (State or foreign country) Wisconsin/ Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Wilson		14. MOTHER'S MAIDEN NAME Emma Thatcher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. (S) Gerald F. Young, 7611 Eastern Ave., SS, Md.	
17. INFORMANT (S) Gerald F. Young, 7611 Eastern Ave., SS, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Inanition DUE TO (c) Complete paralysis from multiple cerebral vascular accidents		INTERVAL BETWEEN ONSET AND DEATH 48 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 2 1960 to Sept. 20 1960 that (I) (we) last saw the deceased alive on Sept. 20 1960 , and that death occurred at 8:30AM M, from the causes and on the date stated above.			
22a. SIGNATURE R. G. Muth		22b. DATE SIGNED 9-20-60	
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-24-60	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince George Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Pumphrey, 8434 Georgia Ave., Silver Spring, Md.		25a. REC'D BY REGISTRAR SEP 22 60	
25b. REGISTRAR'S SIGNATURE Arthur L. Harris			

Eds. Warner E. Pumphrey Inc for W & S Harris

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FOR STATE HEALTH DEPT. (M)
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1. PLACE OF DEATH
a. COUNTY Montgomery **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shuamille & Jean Richard Rd

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Howard
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Highland
d. STREET ADDRESS Mink Hollow Rd e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Samuel Carlton McCann
First Middle Last
4. DATE OF DEATH Sept 27 1960 Month Day Year

5. SEX male **6. COLOR OR RACE** white **7. MARRIED** ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5-22-40 **9. AGE** (In years last birthday) 20 yrs. **IF UNDER 1 YEAR** Months Days **IF UNDER 24 HRS.** Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lat. Tunesian **10b. KIND OF BUSINESS OR INDUSTRY** chemical co. **11. BIRTHPLACE** (State or foreign country) Maryland **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

13. FATHER'S NAME Samuel Adams McCann **14. MOTHER'S MAIDEN NAME** Barbara Lee Keener

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO **16. SOCIAL SECURITY NO.** NO **17. INFORMANT** Robert Lee McCann - Brother Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage & laceration
822X DUE TO multiple
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) compound fracture of skull
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
INTERVAL BETWEEN ONSET AND DEATH sudden

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH.** Driver fault involved in accident - overturning in roadway
20c. TIME OF INJURY Month, Day, Year 10/10 p.m. 9-27 1960 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway **20f. (City or town)** Silver Spring Monty (County) md (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ **Inspection** ☐ **Inquiry** ☐ **and in my opinion death resulted from:** Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ **ASSISTANT MEDICAL EXAMINER** ☐ **DATE SIGNED** 9-28-60
EXAMINER'S SIGNATURE Frank J. Broschart **M.D.** **DEPUTY MEDICAL EXAMINER** ☒ **Address** (Street, city, town, or county) Clarksville Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial **22b. DATE THEREOF** 10/1/60 **22c. NAME OF CEMETERY OR CREMATORY** St. Louis Cem. **22d. LOCATION** (City, town, or country) Clarksville Md (State)

23. FUNERAL DIRECTOR DeWitt Donaldson **24a. REC'D BY REGISTRAR** DA **24b. REGISTRAR'S SIGNATURE** Oct 5 '60 Civilian S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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DEATH
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10516

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle CLIFTON Last MAGRUDER		4. DATE OF DEATH Month SEPT. Day 2 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/20/05
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto mechanic		10b. KIND OF BUSINESS OR INDUSTRY Cave Ford Co.	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WALTER T. MAGRUDER	
14. MOTHER'S MAIDEN NAME CORRIE CASE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 577-10-1734		17. INFORMANT Mrs. Evelyn V. Magruder, 10,818 Newport Mill Rd., Kensington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 10 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 2/21, 1960 to 9/2, 1960 that I last saw the deceased alive on 9/1, 1960 , and that death occurred at 5:30 AM , from the causes and on the date stated above.	
ADDRESS (Street, city or town, state) 10620 Georgia Ave, Silver Spg, Md.		DATE SIGNED 9/2/60	
ACTUAL SIGNATURE Donald Nelson		M.D. 10620 Georgia Ave, Silver Spg, Md.	
PHYSICIAN'S NAME (Type) DONALD NELSON		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 9/6/60		22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY	
22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND		23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.	
24a. REC'D BY REGISTRAR DATE SEP 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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10404

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, MARYLAND c. LENGTH OF STAY IN 1b 2 YRS 5 MO d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND NURSING HOME		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 3823 MASS AVE NW b. COUNTY WASH DC c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC d. STREET ADDRESS 3823 MASS AVE NW e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Anna B. Maloney		4. DATE OF DEATH Month Day Year September 17 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-1891
9. AGE (in years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ROSENBERG		14. MOTHER'S MAIDEN NAME SARAH FISHMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO Cerebral Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO — (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 max years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 1958 to September 17, 1960 that I last saw the deceased alive on September 16, 1960 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Boris Rabkin		DATE SIGNED 9/17/60	
PHYSICIAN'S NAME (Type) BORIS RABKIN		ADDRESS 1019 University Boulevard East Silver Spring, Maryland	
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	SEPT. 20, 1960	ARLINGTON NATIONAL CEMETERY	ARLINGTON VA.
23. FUNERAL DIRECTOR'S SIGNATURE D. Langenberg		24a. REC'D BY REGISTRAR DATE SEP 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PHOTOGRAPHY

STATE OF NEW YORK

IN SENATE

January 10, 1911

REPORT

NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10470

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
c. LENGTH OF STAY IN 1b <u>3 yrs</u>				d. STREET ADDRESS <u>4614 Harrison st</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4614 Harrison st</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Janet Robinson Marks</u>				4. DATE OF DEATH <u>Sept 6 1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-1-1899</u>	
9. AGE (In years, last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Pa</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edw. Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Irma Parvin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Char Marks (husband)</u>				Address <u>Steu 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>hypertension</u> (c) <u>5 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-9-1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Washington, D.C.</u>			
23. FUNERAL DIRECTOR <u>Joseph Sawler's Sons Inc. 1756-Pa. Ave. NW.</u>				24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>							

FOR SMITH
DEPT. OF HEALTH



10138

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Placerville
County
California
11-1-1914
John J. Brown
Male
Single
Occupation: Farmer
Cause of Death: (illegible)
Manner of Death: (illegible)
Time of Death: (illegible)
Place of Death: (illegible)

SET 8-1910

10405

CERTIFICATE OF DEATH

10472

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1702 CHESAPEAKE AVE	
3. NAME OF DECEASED (Type or print) First JOHN Middle VINCENT Last MAREAN		4. DATE OF DEATH Month 9 Day 12 Year 1968	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1905
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) D.C. FIRE DEPT.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) COMBESLAND MO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RAYMOND P. MAREAN		14. MOTHER'S MAIDEN NAME ELIZABETH POWER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT VIOLA MAREAN-702 CHESAPEAKE ST. SILVER SPRING		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Arterio-sclerosis DUE TO Arterio-sclerosis (c) Arterio-sclerosis			INTERVAL BETWEEN ONSET AND DEATH Sudden 2 yrs 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/10 , 19 68 , to 9/12 , 19 68 , that I last saw the deceased alive on 9/12 , 19 68 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Francis X Richardson M.D.		ADDRESS (Street, city or town, state) 11412 Viers Mill Rd. Washington Md.	
DATE SIGNED 9/12/68			
PHYSICIAN'S NAME (Type) FRANCIS X RICHARDSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-15-68	22c. NAME OF CEMETERY OR CREMATORY Mount Oliver	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Harlow ADDRESS 2831 New Ave		24a. REC'D BY REGISTRAR DATE SEP 15 '68	24b. REGISTRAR'S SIGNATURE Arthur L. Kane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10517

10473

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Delaware			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Darby	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 7020 Guilford Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last William Oscar Marrin, Jr.				4. DATE OF DEATH Month Day Year September 13, 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1918		9. AGE (In years lost birthday) yrs. 42	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Artist		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William O. Marrin				14. MOTHER'S MAIDEN NAME Bertha Sitrler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 167-18-6818		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Calcified Aortic Stenosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 11, 1960 to September 13, 1960 , that (I) (we) last saw the deceased alive on Sept. 13, 1960 , and that death occurred at 3:03 p.m. , from the causes and on the date stated above.							
22a. SIGNATURE Benson R. Wilcox, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/14/60	
22c. PHYSICIAN'S NAME (Type) Benson R. Wilcox, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/14/60		23c. NAME OF CEMETERY OR CREMATORY Montrose Cemetery		23d. LOCATION (City, town, or county) (State) Highland Park, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE SEP 15 '60	
				25b. REGISTRAR'S SIGNATURE Carling S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10518
10474
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Fayette ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS (No street address)			
3. NAME OF DECEASED (Type or print) First Albert Middle (None) Last May				4. DATE OF DEATH Month September Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 1, 1906	
9. AGE (In years lost birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Mining		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Milton May				14. MOTHER'S MAIDEN NAME Lilly Ritnour			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 208-07-4216		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pancytopenia DUE TO (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 0				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) August 23, 1960				20g. (County) September 2, 1960			
20h. (State) 1960							
21. I certify that (I) (this hospital) attended the deceased from August 23, 1960 to September 2, 1960 , that (I) (we) last saw the deceased alive on September 2, 1960 , and that death occurred at 8:10 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Edward E. Morse M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-3-60	
22c. PHYSICIAN'S NAME (Type) EDWARD E. MORSE, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 9-3-60		23c. NAME OF CEMETERY OR CREMATORY Normalville Cemetery		23d. LOCATION (City, town, or county) (State) Fayette County, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS BETHESDA, MD.		25a. REC'D BY REGISTRAR SEP 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

1947

CENTRAL RECORDS

10518

THE MEDICAL CENTER, UNIVERSITY OF CALIFORNIA, BERKELEY, CALIF. 94720
RECEIVED
JAN 10 1947
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or letter containing several paragraphs of text, possibly including dates and names.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10475

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

(M)

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NETTIE JUNE Middle MC ACHON Last 5314 Glenwood Rd.		4. DATE OF DEATH Month SEPT. Day 4 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/83
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife	11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME HENRY ASCUE	
14. MOTHER'S MAIDEN NAME MARY CATHERINE REDWINE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT DAUGHTER (MRS. CATHERINE SHREEVE) Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Peripheral phlebitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Fracture neck, right femur DUE TO Fracture neck, right femur IMMEDIATE CAUSE (b) Fracture neck, right femur DUE TO Fracture neck, right femur IMMEDIATE CAUSE (c) Fracture neck, right femur			INTERVAL BETWEEN ONSET AND DEATH Sudden Unknown 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary + Intestinal Tuberculosis, Bilateral confluent bronchopneumonia			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell on bed room floor at home	
20c. TIME OF INJURY Month, Day, Year 5:30 - 8-29-60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Bethesda Md (County) mtg (State) md
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brochart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-60	
22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR SEP 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH

DATE OF DEATH
1957

1. NAME OF DECEASED
2. SEX
3. AGE
4. RACE
5. OCCUPATION
6. PLACE OF BIRTH
7. DATE OF BIRTH
8. MARITAL STATUS
9. PREVIOUS MARRIAGES
10. EDUCATION
11. RELIGION
12. SOCIAL SECURITY NUMBER
13. HOME ADDRESS
14. PHONE NUMBER
15. STREET ADDRESS
16. CITY
17. STATE
18. ZIP CODE
19. COUNTY
20. DISTRICT

21. CAUSE OF DEATH
22. MANNER OF DEATH
23. TIME OF DEATH
24. PLACE OF DEATH
25. SIGNATURE OF MEDICAL EXAMINER
26. SIGNATURE OF WITNESS
27. SIGNATURE OF CORONER
28. SIGNATURE OF JURY
29. SIGNATURE OF JUDGE
30. SIGNATURE OF CLERK

31. SIGNATURE OF DECEASED
32. SIGNATURE OF NEXT OF KIN
33. SIGNATURE OF SURVIVOR
34. SIGNATURE OF ESTATE
35. SIGNATURE OF BENEFICIARY
36. SIGNATURE OF CREDITOR
37. SIGNATURE OF DEBTOR
38. SIGNATURE OF GUARANTOR
39. SIGNATURE OF SURETY
40. SIGNATURE OF WITNESS
41. SIGNATURE OF JURY
42. SIGNATURE OF JUDGE
43. SIGNATURE OF CLERK

NO FEE TO BE PAID BY DECEASED OR NEXT OF KIN FOR THIS CERTIFICATE. IF THE DECEASED OR NEXT OF KIN IS A MEMBER OF THE MARYLAND STATE DEPARTMENT OF HEALTH, THE FEE SHALL BE PAID BY THE DEPARTMENT. IF THE DECEASED OR NEXT OF KIN IS A MEMBER OF THE MARYLAND STATE DEPARTMENT OF HEALTH, THE FEE SHALL BE PAID BY THE DEPARTMENT. IF THE DECEASED OR NEXT OF KIN IS A MEMBER OF THE MARYLAND STATE DEPARTMENT OF HEALTH, THE FEE SHALL BE PAID BY THE DEPARTMENT.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 35 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				1660 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 5610-31st Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Robert Middle Wayne Last McGinthy				4. DATE OF DEATH Month September Day 19 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1956	9. AGE (In years last birthday) 4 yrs.	IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min.	IF UNDER 24 HRS. Months 4 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Archie McGinthy				14. MOTHER'S MAIDEN NAME Margaret Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT The Medical Record address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Central nervous system leukemia DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphatic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 months 21 months						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 15, 1960 to September 19, 1960 , that I last saw the deceased alive on September 19, 1960 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National DATE SIGNED 9/19/60 ACTUAL SIGNATURE W. Walter Oppelt M.D. Institutes of Health, Bethesda, Maryland PHYSICIAN'S NAME (Type) W. Walter Oppelt, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/60		22c. NAME OF CEMETERY OR CREMATORY Fort Snodden		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home, Inc.				24a. REC'D BY REGISTRAR DATE SEP 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

005643

7-10-1953

2507

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

10521
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10477

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfax d. STREET ADDRESS 338 Jean Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Patricia MC NABB				4. DATE OF DEATH Month Day Year September 23 1960											
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-21-60		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months Days Hours Min. 2		IF UNDER 24 HRS. Hours Min. 2			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -				10b. KIND OF BUSINESS OR INDUSTRY - - - - -				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Joseph Michael MC NABB						14. MOTHER'S MAIDEN NAME Mary Evelyn FULLER									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Address (F) Jos. M. McNabb, same as #2 above									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia DUE TO Hyland membrane disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity DUE TO Prematurity PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) exhaustion												INTERVAL BETWEEN ONSET AND DEATH 6 hr 40 hr 44 hr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) exhaustion								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) Sept. 21, 1960 12:20 PM Sept. 23, 1960							
21. I certify that (I) physician attended the deceased from Sept. 21, 1960 12:20 PM to Sept. 23, 1960 that (I) did not see the deceased alive on Sept. 23, 1960 and that death occurred at M , from the causes and on the date stated above.															
22a. SIGNATURE Lawrence G. Thorne 22c. PHYSICIAN'S NAME (Type) L. G. THORNE, LT, MC, USN				M.D. X		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-23-60							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-27-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey R. A. Humphrey Funeral Home, Bethesda, Md.						25a. REC'D BY REGISTRAR DATE SEP 28 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 41 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10522

CERTIFICATE OF DEATH

10478

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda, Md.				d. STREET ADDRESS 235 North Adams Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jack Middle Leon Last McNeil, Jr.				4. DATE OF DEATH Month September Day 23 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 8, 1952	
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min. 7		IF UNDER 24 HRS. Months 7 Days 7 Hours 7 Min. 7			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Student)				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Jack Leon McNeil, Sr.				14. MOTHER'S MAIDEN NAME Barbara Prater			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis 587.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystic Fibrosis of the Pancreas DUE TO (c) Birth INTERVAL BETWEEN ONSET AND DEATH 4 - 6 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville, Md.				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from September 20, 1960 , to September 23, 1960 , that (I) (we) last saw the deceased alive on Sept. 23, 1960 , and that death occurred 6:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE Hugh Evans				22b. DATE SIGNED 9/24/60			
22c. PHYSICIAN'S NAME (Type) HUGH EVANS, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/26/60		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler				25a. REC'D BY REGISTRAR SEP 28 '60			
25b. REGISTRAR'S SIGNATURE Charles L. Hines							

MEDICAL CERTIFICATION

(M)

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10479

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 22 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8614 Garfield Street		e. STREET ADDRESS 8614 Garfield Street	
3. NAME OF DECEASED (Type or print) First Aloise Middle G. Last MELTON		4. DATE OF DEATH Month September Day 23 , Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1908
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 3 Days 2	
11. IF UNDER 24 HRS. Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME E. Charlton Graves		14. MOTHER'S MAIDEN NAME Roma Corson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph C. Melton-Same Item #2 - Husband		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED September 23, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9/24/1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR SEP 26 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kiser	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED Robert A. Humphrey		AGE 62 years		SEX Male		RACE White	
RESIDENCE 881 - Carlton Street		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
DATE OF DEATH June 21, 1908		HOUR 10:30 A.M.		PLACE Home		CITY Baltimore	
DECEASED'S OCCUPATION None		CAUSE OF DEATH Coronary Occlusion		MANNER OF DEATH None		PLACE OF DEATH Home	
DECEASED'S MARITAL STATUS Married		NAME OF SPOUSE Joseph C. Melton-Same Item 42 - husband		DECEASED'S RELIGION Roman Catholic		DECEASED'S EDUCATION High School	
DECEASED'S BIRTH DATE September 25, 1846		DECEASED'S BIRTH PLACE Shields, Maryland		DECEASED'S PRESENT ADDRESS 881 - Carlton Street		DECEASED'S PRESENT CITY Baltimore	
DECEASED'S PRESENT STATE Maryland		DECEASED'S PRESENT COUNTY Baltimore		DECEASED'S PRESENT CITY Baltimore		DECEASED'S PRESENT STATE Maryland	

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1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10480

10524

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Germantown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle HENDERSON Last Merrill		4. DATE OF DEATH Month September Day 29 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1873
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 11 Days 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Tex Texas
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME William Henderson	
14. MOTHER'S MAIDEN NAME Elizabeth Nelson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Thomas Kelley-daughter-same 22d	
17. ADDRESS 		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema disease DUE TO arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) advanced senility	
INTERVAL BETWEEN ONSET AND DEATH 36 hours 1 year 3 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that I attended the deceased from Jan , 19 48 , to Sept 29 , 19 60 , that I last saw the deceased alive on Sept 29 , 19 60 , and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darnestown, Md DATE SIGNED 9/29/60			
ACTUAL SIGNATURE John G. Fawcett		M.D. P. O. Boyd, Md	
PHYSICIAN'S NAME (Type) John G. Fawcett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/60	
22c. NAME OF CEMETERY OR CREMATORY Darnestown Cemetery		22d. LOCATION (City, town, or county) (State) Darnestown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR OCT 3 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1952

State of New York

County of ...

City of ...

Dec. 11, 1952

Attest: ...

Witness my hand and seal of office this 11th day of December, 1952.

Notary Public for the State of New York

John ...

No. ...

...

...

...

...

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10526

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		b. COUNTY	
Montgomery				Maryland		Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Bethesda		26 days		34 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Suburban				3907 Isbell St.,			
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
Lena						Meyrowitz	
4. DATE OF DEATH		Month		Day		Year	
Sept.		16		19		60	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		White				7/10/85	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
75		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Poland		U.S.A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
UNKNOWN		Friedman					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no		no		Leon Meyrowitz		3907 Isbell St. Silver Sp. Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		b. RIGHT ILLIAC ARTERY (1 week)		c. HYPERTENSIVE CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
443X		DUE TO				15 Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour o. m. p. m.		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from April 1960 to Sept 16, 1960 that (I) (we) last saw the deceased alive on Sept 16, 1960, and that death occurred at 3:45 M, from the causes and on the date stated above.							
22a. SIGNATURE		22b. DATE SIGNED					
Morris Perry							
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS					
Morris Perry, M.D.		11602 Georgia Ave., Wheaton, Maryland					
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
BURIAL		Sept 18, 1960		Mt. Zion Cemetery		New York City N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
B. Hansson		DATE SEP 21 '60		Charles S. Huns			

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• **ADP/ATP**

5

CERTIFICATE OF DEATH

Reg. Dist. No.

10484

10451

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> <i>Kensington</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD.</i> <i>District of Columbia</i> COUNTY <i>of Columbia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i>		c. LENGTH OF STAY IN 1b <i>one and one half years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Le Deau Gardens (Home)</i>		d. STREET ADDRESS <i>5122 PIARGLEN LANE</i> <i>8646 Chesapeake St. N.E.</i>	
3. NAME OF DECEASED (Type or print) First <i>Ella</i> Middle <i>N.</i> Last <i>Mitholland</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/3/03</i>
9. AGE (In years last birthday) <i>56</i> yrs.		IF UNDER 1 YEAR Months <i>56</i> Days <i>56</i> Hours <i>56</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TELEPHONE OPERATOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ANSWERING SERVICE</i>	11. BIRTHPLACE (State or foreign country) <i>GARRETT PARK, MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>EPPA NORRIS</i>	
14. MOTHER'S MAIDEN NAME <i>LULA LASKEY</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>Yes-530-1985</i>		17. INFORMANT <i>Mr. Eppa L. Norris, 5425 Conn. Ave., N.W.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cholangiolitis hepatitis</i> DUE TO <i>2 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Viral hepatitis</i> DUE TO <i>5 years</i> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Pyelonephritis, Cachexia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Noon</i> <i>28</i> , 19 <i>59</i> , to <i>August</i> <i>1960</i> that I last saw the deceased alive on <i>July 28</i> , 19 <i>60</i> , and that death occurred at <i>8:40 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Allen J. O'Neill</i>		ADDRESS (Street, city or town, state) <i>8601 Old Georgetown Rd.</i>	
PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		DATE SIGNED <i>9/4/1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>9/6/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>GLENWOOD CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner E. Bumphrey, Inc.</i> <i>Raymond A. Ziska</i>		ADDRESS <i>SILVER SPRING, MD.</i>	
24a. REC'D BY REGISTRAR <i>SEP 7 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Case deemed with coroner and approved.

TELEPHONE OPERATOR ANSWERING SERVICE GARRETT PARK, MARYLAND U.S.A.

EPBA NORRIS

JULIA LASKEY

OI

29Y

Mr. Epps L. Norris, 2425 Conn. Ave., N.W.
Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10527

10485

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>11123 Rokeby Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Rita</u> Middle <u>Mary</u> Last <u>Millard</u>		4. DATE OF DEATH Month <u>September</u> Day <u>27</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 19, 1920</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>North Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Messing</u>		14. MOTHER'S MAIDEN NAME <u>Rose</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT (Husband) <u>Robert Millard</u>		Address <u>As above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> DUE TO (b) <u>Metastatic carcinoma breast</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>18 mos</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>27 Aug 1960</u> , that (I) (we) last saw the deceased alive on <u>26 Aug 1960</u> and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton</u>		22b. DATE SIGNED <u>27 Aug '60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>		22d. ADDRESS <u>10511 Sumit Ave. Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/30/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 30 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10528

10486

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring		c. LENGTH OF STAY IN 1b 71 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "Plamfield"		d. STREET ADDRESS Plamfield	
3. NAME OF DECEASED (Type or print) WILSON WILSON MOORE		4. DATE OF DEATH Month 9 Day 11 Year 1960	
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 12-12-1888
9. AGE (In years lost birthday) yrs. 71		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orchardist		10b. KIND OF BUSINESS OR INDUSTRY Orchard	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Rowland Moore		14. MOTHER'S MAIDEN NAME Margaret G. Tyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-348961	
17. INFORMANT Helen W. Moore		Address Sandy Spring, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Intestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Obstructive jaundice DUE TO (c) Carcinoma of head of pancreas states		INTERVAL BETWEEN ONSET AND DEATH 6 wks 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 5, 1960 to 9/11/60 , that (I) (we) last saw the deceased alive on 9/11/60 , and that death occurred at 5:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE C. H. L. Hagan		22b. DATE SIGNED 9/12/60	
22c. PHYSICIAN'S NAME (Type) C. H. L. Hagan		22d. ADDRESS SANDY SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 9/12/60	
23c. NAME OF CEMETERY OR CREMATORY Fl. Lincoln		23d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home		25a. REC'D BY REGISTRAR SEP 14 '60	
ADDRESS 1331 E. Montgomery Ave. Rockville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

Tyson Wheeler, p. 11

CERTIFICATE OF DEATH

(M)

1. Name of deceased *John Doe*
2. Age *45*
3. Sex *Male*
4. Date of death *Jan 15 1925*
5. Place of death *Home*
6. Cause of death *Heart disease*
7. Signature of physician *J. H. Smith*
8. Signature of registrar *W. B. Jones*
9. Signature of undertaker *W. B. Jones*
10. Signature of witness *W. B. Jones*

11. Date of burial *Jan 16 1925*
12. Place of burial *Cemetery*
13. Signature of registrar *W. B. Jones*
14. Signature of undertaker *W. B. Jones*
15. Signature of witness *W. B. Jones*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
16529
CERTIFICATE OF DEATH

10487

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48 Chevy Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Sylvester Morningstar</u>				4. DATE OF DEATH Month Day Year <u>Sept. 11 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/29/10</u>	
9. AGE (In years lost birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoeham Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>Algia Morningstar</u>		14. MOTHER'S MAIDEN NAME <u>Fannie M. Orme</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>24-63-7382</u>		17. INFORMANT <u>Alice Morningstar/ Same as above.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Failure</u> DUE TO <u>Cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pleuritis with effusion, right</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>9/5/60</u> 19 <u>60</u> , to <u>11 Sept.</u> 19 <u>60</u> , that (II) (we) last saw the deceased alive on <u>11 Sept.</u> 19 <u>60</u> , and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert Young</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/11/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT YOUNG</u>				22d. ADDRESS <u>4740 Bradley Blvd. Ch. Ch. 15 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/15/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Beallsville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lynn Wheeler</u>				ADDRESS <u>1331 E. Montgomery</u>		25a. REC'D BY REGISTRAR <u>SEP 14 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>C. L. H. Hines</u>	

BP

CERTIFICATE OF DEATH

17351

urs after death. Page

by the funeral director,
who should be filed with

TO HUSBAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director.

CERTIFICATE OF DEATH

10437

10488

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase,,			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Chevy Chase				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7102 Meadow Lane				d. STREET ADDRESS 7102 Meadow Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NORMAN		First J.		Middle MORRISON		4. DATE OF DEATH Month Sept. Day 25 Year 19 60				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/30/1893		9. AGE (In years last birthday) 67 yrs. IF UNDER 1 YEAR: Months 0 Days 25 Hours Min. IF UNDER 24 HRS. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer			10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (State or foreign country) Texas			12. CITIZEN OF WHAT COUNTRY? US		
13. FATHER'S NAME James S. Morrisson				14. MOTHER'S MAIDEN NAME Herminiah Ern						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary Morrisson-wife-same 2d						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 hepatic coma DUE TO (b) carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) carcinoma of colon DUE TO								INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 2+ MONTHS 6+ MONTHS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MAY 1960 to 9/25 1960 , that (I) (we) last saw the deceased alive on 9/25 1960 , and that death occurred at 12 P.M. , from the causes and on the date stated above.										
22a. SIGNATURE Charles Savarese, MD M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/25/60			
22c. PHYSICIAN'S NAME (Type) CHARLES SAVARESE MD					22d. ADDRESS 4890 BATTERY LANE BETHESDA, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION (City, town, or county) (State) Washington, D. C.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey					ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR SEP 27 '60		25b. REGISTRAR'S SIGNATURE Charles S. Morrisson	

MEDICAL CERTIFICATION

This should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and send to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

10433

(M)

Given by: Mary Jones
 Date: 1903
 Place: New York City
 Cause of Death: ...
 Signature: ...
 Date: ...
 Place: ...

Witness: ...
 Date: ...
 Place: ...

Witness: ...
 Date: ...
 Place: ...

Witness: ...
 Date: ...
 Place: ...

Witness: ...
 Date: ...
 Place: ...

Witness: ...
 Date: ...
 Place: ...

Witness: ...
 Date: ...
 Place: ...

Witness: ...
 Date: ...
 Place: ...

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1/14
FOR STATE
HEALTH DEPT.

(M)

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2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10489

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Chelmsford</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>8 hrs</u>		d. STREET ADDRESS <u>#3 Oswego Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chelmsford Rd, English Manor</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Walker Mosley</u>		4. DATE OF DEATH <u>Sept 27 1960</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-1-1905</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bulldozer operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>WINFIELD, LA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>JIM MOSLEY</u>		14. MOTHER'S MAIDEN NAME <u>NANCY MC WRIGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>21409148</u>	
17. INFORMANT <u>LORETTA MOSLEY</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Insufficiency</u> (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9-28-60</u>	
Address (Street, city, town, or county) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/1/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>National Harmony</u>		22d. LOCATION (City, town, or country) (State) <u>Prince George's Maryland</u>	
23. FUNERAL DIRECTOR <u>John T. Rhines & Co.</u>		24a. REC'D BY REGISTRAR <u>SEP 30 '60</u>	
Address <u>3015-12th St, N.E.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	

03701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10490

10424

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 18 d. STREET ADDRESS <u>32 Mississippi Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marguerette Ashby Motte</u>			4. DATE OF DEATH <u>Sept 6 1960</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-10-00</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Dep't. Wash D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Alfred B. Drew</u>				
14. MOTHER'S MAIDEN NAME <u>Gertrude Newton</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				
16. SOCIAL SECURITY NO. <u>Hospital Records</u>			17. INFORMANT <u>Hospital Records</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>175.0 Congestive Cardiac Failure</u> DUE TO <u>Metastatic Carcinoma - Ovarian</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1958</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Sept 6</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 6</u> , 19 <u>60</u> , and that death occurred at <u>11:45</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>1600 Carroll Ave, T.P. Md.</u>		DATE SIGNED <u>9/6/60</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Sept. 9, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u>	22d. LOCATION (City, town, or county)	(State) <u>Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Takoma Funeral Home</u>		ADDRESS <u>257 Carroll St. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>SEP 8 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10531

10491

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i> COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>				d. STREET ADDRESS <i>4917 42nd St., Wash., D.C.</i>			
3. NAME OF DECEASED (Type or print) First <i>Peter</i> Middle <i>muscato</i> Last <i>jr.</i>				4. DATE OF DEATH Month <i>9</i> Day <i>26</i> Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/19/83</i>	9. AGE (In years last birthday) <i>77</i> yrs.	IF UNDER 1 YEAR Months <i>11</i> Days <i>17</i> Hours <i>11</i> Min.		IF UNDER 24 HRS. Hours <i>11</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Italy.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Anthony muscato</i>				14. MOTHER'S MAIDEN NAME <i>Anna ?</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no.</i>		16. SOCIAL SECURITY NO. <i>015-16-2804</i>		17. INFORMANT <i>Rose M. Bonfigliop (Daughter)</i> Address <i>4917 42nd St. Washington, D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1 UREMIA (NEPHROTIC SYNDROME)</i> DUE TO (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO (c) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1+ WEEK</i> <i>1+ 1/2</i> <i>10+ 1/2</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from <i>JAN 1957</i> to <i>9/26</i> 1960, that (I) (we) last saw the deceased alive on <i>9/25</i> 1960, and that death occurred at <i>5:45</i> AM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles Savarese M.D.</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>9/26/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>CHARLES SAVARESE, M.D.</i>				22d. ADDRESS <i>4800 BATTERY LANE BETHESDA, MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<i>burial-transit</i>		<i>9-29-60</i>		<i>St. Bernards Cem.</i>		<i>Concord, Massachusetts</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Humphrey</i> ADDRESS <i>Bethesda, Maryland</i>				25a. REC'D BY REGISTRAR <i>SEP 27 '60</i> DATE		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



CERTIFICATE OF DEATH

Reg. Dist. No.

10492

10532

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Nejako</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/17/60</u>	
9. AGE (In years lost birthday) yrs. <u>1</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Mark E. Nejako</u>				14. MOTHER'S MAIDEN NAME <u>Nancy J. Rinker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT <u>parents</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept. 17, 1960</u> , to <u>Sept. 17, 1960</u> that I last saw the deceased alive on <u>Sept. 17, 1960</u> , and that death occurred at <u>8:09</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen C. Cromwell</u>				ADDRESS (Street, city or town, state) <u>615 W. Montgomery Avenue 98/17/60</u>			
PHYSICIAN'S NAME (Type) <u>Stephen C. Cromwell</u>				DATE SIGNED <u>9/17/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Rumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 20 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE HEALTH DEPT. (M)
TO DELAY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10493

1. PLACE OF DEATH e. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 505 Tulip Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Edgar New		4. DATE OF DEATH Month Sept Day 10 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/3/1869
9. AGE (In years last birthday) 91		10. IF UNDER 1 YEAR Months 10 Days 10	
11. IF UNDER 24 HRS. Hours 10 Min. 10		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. W. New		14. MOTHER'S MAIDEN NAME Susan Stickman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Item 2	
17. INFORMANT Henrietta E. New (wife)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fell dead on kitchen floor		INTERVAL BETWEEN ONSET AND DEATH fell dead on kitchen floor	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9/11/60	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 13, 1960	
22c. NAME OF CEMETERY OR CREMATORY NATIONAL MEMORIAL PARK		22d. LOCATION (City, town, or country) (State) FALLS CHURCH, VA	
23. FUNERAL DIRECTOR Arthur S. Hanna		24a. REC'D BY REGISTRAR SEP 13 '60	
ADDRESS WASHINGTON 12, D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10494

10533

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Dist. of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 80 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 3945-Conn. Ave. N.W. Apt 4 08		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Helen T. Noren				4. DATE OF DEATH Sept. 16, 1960		Month Sept. Day 16 Year 1960	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1890	
9. AGE (In years lost birthday) 69 yrs.		IF UNDER 1 YEAR Months 69 Days 69 Hours 69 Min.		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				10b. KIND OF BUSINESS OR INDUSTRY C.I.A.		11. BIRTHPLACE (State or foreign country) Minnesota	
13. FATHER'S NAME Frank Noren				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Nephew Verele Lyberg		18. ADDRESS 1421 Arch St. Phila., Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure DUE TO Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 weeks DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-4-55 to 9-16-60 , that (I) was last saw the deceased alive on 9-16-60 , and that death occurred at 5:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE C. Roger Runtz				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-16-60	
22c. PHYSICIAN'S NAME (Type) C. Roger Runtz				22d. ADDRESS 370 Connechee Avenue Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 9-17-60		23c. NAME OF CEMETERY OR CREMATORY Hill Side Cemetery		23d. LOCATION (City, town, or county) (State) Minneapolis, Minn.	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR SEP 20 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

75157 Macman Ave Bethesda, Md

CERTIFICATE OF DEATH

State of Colorado
County of _____
Decedent's Name _____
Age _____
Sex _____
Date of Death _____
Place of Death _____
Cause of Death _____
Physician's Signature _____
Date _____
Registrar's Signature _____
Date _____

1

After the death of _____
the body was _____
by _____
on _____
at _____
The body was _____
by _____
on _____
at _____
The body was _____
by _____
on _____
at _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3819 Woodbine St. 51</u>		d. STREET ADDRESS <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Veronica O'Connor</u>		4. DATE OF DEATH Month Day Year <u>Sept 8 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-88</u>
9. AGE (In years lost birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Cummer</u>		14. MOTHER'S MAIDEN NAME <u>Adelaide Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Eunice McDonald-Same</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure - acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Massive Hemorrhage</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1958</u> to <u>9-8</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9-8</u> 19 <u>60</u> , and that death occurred at <u>5:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>James Scully</u>		22b. DATE SIGNED <u>9/8/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Scully, M.D.</u>		22d. ADDRESS <u>1835 I St. N.W. Wash. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G272 10-3-60 et

10496

CERTIFICATE OF DEATH

Reg. Dist. No.

10496

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Montgomery Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8709 Plymouth St.</u>		d. STREET ADDRESS <u>8709 Plymouth St</u>	
3. NAME OF DECEASED (Type or print) First <u>KAE MON</u> Middle <u>OKUMURA</u> Last <u>OKUMURA</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OF EYES <u>YELLOW</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 2 1896</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHef</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u>	
11. BIRTHPLACE (State or foreign country) <u>Japan</u>		12. CITIZEN OF WHAT COUNTRY? <u>Japan</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Frank Ruge (FRIEND)</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, Chronic</u> DUE TO <u>Hypertension and Coronary Arteriosclerosis</u> DUE TO <u>Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>Sept 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William S. Miller</u> M.D.		ADDRESS (Street, city or town, state) <u>1835 EYE ST N. W.</u> DATE SIGNED <u>Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>William S. Miller, M.D.</u>		<u>Wash D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION 9/29/60</u>		22b. DATE THEREOF <u>9/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM</u>		22d. LOCATION (City, town, or county) (State) <u>PR. GR. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W R Hunsinger & Son</u>		ADDRESS <u>5732</u>	
24a. REC'D BY REGISTRAR <u>SEP 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. K...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10535

10497

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Accomack ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 65 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 100 Market Street	
3. NAME OF DECEASED (Type or print) First Elsie Middle Mae Last Payne		4. DATE OF DEATH Month September Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1903
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min. 28	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY None	
11c. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred B. Booth		14. MOTHER'S MAIDEN NAME Elizabeth Hall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple myeloma DUE TO (c) 10 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2 weeks			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 25 19 60 , to September 28 19 60 , that (I) (we) last saw the deceased alive on Sept. 28 19 60 , and that death occurred at 7:53AM from the causes and on the date stated above.			
22a. SIGNATURE W. Walter Oppelt, M.D.			
22b. DATE SIGNED 9/28/60			
22c. PHYSICIAN'S NAME (Type) W. Walter Oppelt, M.D.			
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 9/30/60			
23c. NAME OF CEMETERY OR CREMATORY Greenwood			
23d. LOCATION (City, town, or county) (State) Chincoteague, Va			
24. FUNERAL DIRECTOR'S SIGNATURE Charles Williams			
ADDRESS ONANCOCK, Va			
25a. REC'D BY REGISTRAR SEP 30 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CERTIFICATE OF DEATH

1915

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10498

10407

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ALTHEA GLENN NURSING HOME</u>		d. STREET ADDRESS <u>820 N. KENMORE ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>MABEL</u> Middle <u>POTTER</u> Last <u>PAYNE</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/27/1867</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H. POTTER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH VAIL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>CAPT. THOMAS E. PAYNE, MCLEAN, VA. SON</u>		Address <u>4109 FOREST LANE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO <u>Senility</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1959</u> to <u>Sept 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept 15 1960</u> , and that death occurred at <u>100 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>		22b. DATE SIGNED <u>9-17-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>		22d. ADDRESS <u>217 UNIVERSITY BLVD., S. S., MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	23b. DATE THEREOF <u>9/19/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>	23d. LOCATION (City, town, or county) (State) <u>SUITLAND, MD</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Savlers Sons</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 21 '60</u>	
ADDRESS <u>WASHINGTON 1756 PA. AVE. NW DC</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	

CERTIFICATE OF DEATH

66111

[Faint, illegible handwritten text]

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66111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10536
CERTIFICATE OF DEATH

10499

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 150 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1435 Sheridan Street, N.W.			
3. NAME OF DECEASED (Type or print) First Daniel Middle Ivan Last Perlow				4. DATE OF DEATH Month September Day 7 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 11, 1943	
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sydney Perlow				14. MOTHER'S MAIDEN NAME Bertha Sager			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO 197.9 Brain Stem Compression of Fibrosarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 years DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10, 1960 to September 7, 1960 , that (I) (we) last saw the deceased alive on September 7, 1960 , and that death occurred at 12:35 AM from the causes and on the date stated above.							
22a. SIGNATURE Philip J. Ferris, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9/7/60	
22c. PHYSICIAN'S NAME (Type) Philip J. Ferris, M. D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-8-60		23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cemetery		23d. LOCATION (City, town, or county) (State) Oxon Hill, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE B. Danzansky & Sons				ADDRESS 3501 14th St., NW		25a. REC'D BY REGISTRAR DATE SEP 9 '60	
				25b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1921

State of Colorado

County of _____

City of _____

I, _____, of the County of _____, State of Colorado, do hereby certify that _____

_____ was born _____ at _____

_____ on _____ at _____

_____ and died _____ at _____

_____ on _____ at _____

_____ in the _____ of _____

_____ at _____

_____ on _____

_____ at _____

_____ in the _____ of _____

_____ on _____ at _____

_____ in the _____ of _____

April 10 1921

1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10500

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 9. STATE <i>D.C.</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	c. LENGTH OF STAY IN 1b <i>9 days-9 hours</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Seeburian</i>		d. STREET ADDRESS <i>3031 Nash P lace, S. E.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>L</i> Last <i>Perry</i>		4. DATE OF DEATH Month <i>Sep</i> t. Day <i>9</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/16/04</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>66</i> Days <i>66</i> Hours <i>66</i> Min. <i>66</i>	IF UNDER 24 HRS. Months <i>66</i> Days <i>66</i> Hours <i>66</i> Min. <i>66</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Practical Nurse</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Nursing</i>	11. BIRTHPLACE (State or foreign country) <i>Bethesda, Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Benjamin Perry</i>	
14. MOTHER'S MAIDEN NAME <i>Annie Brewer</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address <i>Mr. J. Wilbert Perry 3031 Nash P lace, Wash, D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple pulmonary emboli, bilateral</i> DUE TO <i>Peripheral thrombophlebitis (legs)</i> DUE TO <i>Cellulitis of foot</i>			INTERVAL BETWEEN ONSET AND DEATH <i>9 days</i> <i>2 wks</i> <i>2 wks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <i>July</i>		(County) <i>to 9 Sept. 1960</i>	
21. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>July</i> 19 <i>60</i> to <i>9 Sept. 1960</i> that (I) <i>(we)</i> last saw the deceased alive on <i>9 Sept. 1960</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Roger Kutz</i>		M.D. <i>Attending Phys.</i>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <i>C. Roger Kutz M.D.</i>		22d. ADDRESS <i>361 Connecticut Ave. N.W. Wash, D.C.</i>	
22e. DATE SIGNED <i>9-9-60</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>9/13/60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Suitland, Maryland</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	25a. REC'D BY REGISTRAR <i>SEP 14 '60</i>
25b. REGISTRAR'S SIGNATURE <i>Clifton L. Kline</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10501

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase - 15</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase - 15</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6208 Highland Dr</u>				d. STREET ADDRESS <u>6208 Highland Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Wallace Francis Peterson</u>				4. DATE OF DEATH <u>Sept 14 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-26-1908</u>	
9. AGE (If years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive - Nat. Eng. Products corp.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Utah</u>			
11. BIRTHPLACE (State or foreign country) <u>Utah</u>				12. CITIZEN OF WHAT COUNTRY? <u>M.S.C</u>			
13. FATHER'S NAME <u>Peter Peterson</u>				14. MOTHER'S MAIDEN NAME <u>Rachael Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT <u>Fay Peterson (wife)</u>				Address <u>Steu 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cormary occlusion</u> 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>9-14-60</u> Address (Street, city, town, or county)							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>9-16-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ROCKVILLE, MONTGOMERY Co., MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	
23. FUNERAL DIRECTOR <u>Joseph Gaudin's Sons, Inc. Wash. DC</u>				24a. REC'D BY REGISTRAR <u>SEP 16 '60</u>		24b. REGISTRAR'S SIGNATURE	

100-100000
100-100000

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10452

CERTIFICATE OF DEATH

10502

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL HALL SANITARIUM</u>		d. STREET ADDRESS <u>10231 CARROLL PLACE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>J.</u> Last <u>PROCTOR</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-1871</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>— — —</u>	11. BIRTHPLACE (State or foreign country) <u>INDIANA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>			
13. FATHER'S NAME <u>CHARLES GWYNNE</u>		14. MOTHER'S MAIDEN NAME <u>MARIA PRESTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	17. INFORMANT <u>STUART E. PROCTOR</u> Address <u>(SON)</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>ESSENTIAL HYPERTENSION</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>SEPT. 5</u> , 19 <u>59</u> , to <u>SEPT. 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>SEPT. 11</u> , 19 <u>60</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neuman Lowden</u> M.D.		ADDRESS (Street, city or town, state) <u>5206 Norway Dr.</u>	
PHYSICIAN'S NAME (Type) <u>Chen Chao, M.D.</u>		DATE SIGNED <u>9/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9-13-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY WASHINGTON, DC.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawton's Sons</u>		ADDRESS <u>1756 Pa. Ave. Wash. D.C.</u>	24a. REC'D BY REGISTRAR <u>SEP 13 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10426

CERTIFICATE OF DEATH

10503

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>20 minutes</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>6616 Gude Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Arby</u> Middle <u>Clifton</u> Last <u>Pyles</u>		4. DATE OF DEATH Month <u>September</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1907</u> <u>July 20, 1907</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Pyles</u>		14. MOTHER'S MAIDEN NAME <u>Anna Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>World War 2</u>		16. SOCIAL SECURITY NO. <u>Washington Sanitarium & Hospital Records</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION WITH MYOCARDIAL FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>CORONARY THROMBOSIS, ACUTE, RIGHT.</u> DUE TO (c) <u>2 TO 4 DAYS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 TO 4 DAYS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 27, 1960</u> to <u>Aug 31, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug 31, 1960</u> , and that death occurred at <u>11</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Ernest L. Serrano MD</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 13 60</u>	
ADDRESS <u>4812 St Anne Rd</u>		25b. REGISTRAR'S SIGNATURE <u>James E. Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10538

CERTIFICATE OF DEATH

10504

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHEATON, MD</u>		c. LENGTH OF STAY IN 1b <u>June 6-1960</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>WHEATON NURSING HOME WHEATON, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u>	
3. NAME OF DECEASED (Type or print) <u>CHRISTINE BEATRICE RABBITT</u>		d. STREET ADDRESS <u>724-3rd STREET, N.W.</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 31, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED G. McKENSIE</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA GASKINS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>MISS LEAH RABBITT-460-W-24th ST. NEW YORK CITY</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO <u>Diabetes Mellitus</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>10 years</u> <u>25 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>January, 1947</u> , to <u>Sept 20, 1960</u> , that I last saw the deceased alive on <u>Sept 11, 1960</u> , and that death occurred at <u>10:58 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Perkins</u>		DATE SIGNED <u>9/20/60</u>	
PHYSICIAN'S NAME (Type) <u>W. ROBERT PERKINS</u>		ADDRESS (Street, city or town, state) <u>1463-Rock Island Ave NW Wash DC.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9/23/1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) <u>PRINCE GEORGE CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carly Staffed</u>		ADDRESS <u>475-H N. X Road D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

10044

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>10/15/1965</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. DATE OF BIRTH <i>10/15/1900</i>		11. PLACE OF BIRTH <i>Baltimore, Md.</i>		12. OCCUPATION <i>Retired</i>	
13. MARITAL STATUS <i>Married</i>		14. DATE OF MARRIAGE <i>1925</i>		15. NAME OF SPOUSE <i>JOHN J. SMITH</i>	
16. NAME OF PHYSICIAN <i>DR. J. H. SMITH</i>		17. NAME OF HOSPITAL <i>St. Mary's Hospital</i>		18. NAME OF NURSE <i>JOHN J. SMITH</i>	
19. NAME OF FUNERAL HOME <i>JOHN J. SMITH</i>		20. NAME OF CEMETERY <i>JOHN J. SMITH</i>		21. NAME OF BURIAL PLACE <i>JOHN J. SMITH</i>	
22. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		23. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		24. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
25. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		26. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		27. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
28. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		29. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		30. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
31. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		32. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		33. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
34. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		35. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		36. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
37. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		38. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		39. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
40. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		41. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		42. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
43. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		44. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		45. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
46. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		47. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		48. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
49. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		50. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		51. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
52. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		53. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		54. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
55. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		56. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		57. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
58. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		59. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		60. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
61. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		62. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		63. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
64. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		65. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		66. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
67. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		68. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		69. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
70. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		71. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		72. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
73. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		74. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		75. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
76. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		77. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		78. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
79. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		80. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		81. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
82. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		83. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		84. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
85. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		86. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		87. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
88. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		89. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		90. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
91. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		92. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		93. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
94. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		95. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		96. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
97. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		98. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		99. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	
100. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		101. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>		102. NAME OF NEXT OF KIN <i>JOHN J. SMITH</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10408

CERTIFICATE OF DEATH

10505

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRINGS</u>		c. LENGTH OF STAY IN 1b <u>7 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARILEA REST HOME</u>		d. STREET ADDRESS <u>1100 K Street NE</u>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Ready</u> Last <u>Ready</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1 1859</u>
9. AGE (If years last birthday) <u>101</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Ready</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Walsh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>REV. S.R. Potts</u>		Address <u>Georgetown Univ</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocardial infarction</u> DUE TO <u>1 year</u> (c) <u>General arteriosclerosis</u> DUE TO <u>1 year</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-14</u> 19 <u>58</u> , to <u>Sept 7</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Sept 6 1960</u> , and that death occurred <u>5⁴⁵</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>John S. Rogers, M.D.</u>		22b. DATE SIGNED <u>Sept 7, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>John S. Rogers M.D.</u>		22d. ADDRESS <u>1919 Seminary Rd Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Sept 10 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) <u>WASH D.C.</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Potts</u>			

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
DIVISION OF VITAL RECORDS
SAN FRANCISCO, CALIF.

1949

(M)

(1)

2.7

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

10539

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10506

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 25 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 820 Connecticut Ave., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Holden Middle Chester Last RICHARDSON		4. DATE OF DEATH Month September Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-78
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William RICHARDSON		14. MOTHER'S MAIDEN NAME Elmira J. DOUGHY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI & WWII	
17. INFORMANT Mrs. Diana RICHARDSON, Same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4790X Uremia DUE TO (b) Cardio-renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Pneumonia bilateral (staphylococcus) DUE TO (a) cholecystectomy & cholelithostomy on 8-16-60-		INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-5- 1960 to 9-2- 1960 , that (I) (we) last saw the deceased alive on 9-2-60 19 , and that death occurred at 6:05AM from the causes and on the date stated above.			
22a. SIGNATURE L. J. Hines		22b. DATE SIGNED 9-2-60	
22c. PHYSICIAN'S NAME (Type) L. J. HINES, CDR, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-7-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Grawler & Son		25a. REC'D BY REGISTRAR SEP 7 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		25c. ADDRESS 1756 Penn. Ave., N.W. Wash. D.C.	

CENTRAL BUREAU OF INVESTIGATION

105-10000



U. S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.
JAN 10 1951
MEMORANDUM FOR THE DIRECTOR
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum format with fields for TO, FROM, SUBJECT, and BODY.]

CONFIDENTIAL

MAILED 11-10-51

Very truly yours,
[Illegible Signature]

Special Agent in Charge, [Illegible]
[Illegible text at the bottom of the page]

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 10540
 MONTGOMERY MARYLAND
 BETHESDA D.C.
 Suburban
 112315 Middle Road
 Sept 1 1960
 male white
 child
 John A. Riley
 571.0
 Aspiration of gastric contents
 Intercerebral Edema
 Acute enterocolitis
 Sudden
 Sudden
 4 days
 23 July 1958 to 1 September 1960
 31 August 1960
 KATHARINE A. CHAPMAN
 ROBERT A. PUMPHREY
 3924 Baltimore St., Kensington, Md.
 SEP 7 '60
 Arthur S. Frank

10507

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda D.C.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2500 Viers Mill Village</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>112315 Middle Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gerald Kevin Riley</u>				4. DATE OF DEATH Month Day Year <u>Sept 1 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 July 1958</u>	
9. AGE (In years lost birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John A. Riley</u>				14. MOTHER'S MAIDEN NAME <u>Madeline Poper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Madeline Riley / Mother</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of gastric contents</u> DUE TO <u>571.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intercerebral Edema</u> DUE TO <u>—</u> (c) <u>Acute enterocolitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u> <u>4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>23 July 1958</u> to <u>1 September 1960</u> , that (I) (we) last saw the deceased alive on <u>31 August 1960</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Katharine A. Chapman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept 1, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>KATHARINE A. CHAPMAN</u>				22d. ADDRESS <u>3924 Baltimore St., Kensington, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-6-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

CERTIFICATE OF DEATH

100-10

100-10

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document. The text appears to be organized into sections, possibly corresponding to the fields of a death certificate.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10541

10508

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Arlington</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>				c. LENGTH OF STAY IN 1b <u>145 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Virginia</u>				d. STREET ADDRESS <u>5622 Yorktown Blvd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Dinsmore</u> Last <u>ROSS</u>				4. DATE OF DEATH Month <u>September</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-3-13</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Officer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Harry Reath ROSS</u>				14. MOTHER'S MAIDEN NAME <u>Mary MUSTARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1938 to DOD</u>				16. SOCIAL SECURITY NO. <u>509-03-2436</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, pancreas, with metastases</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (the hospital) attended the deceased from <u>April 26, 1960</u> to <u>Sept. 18, 1960</u> that (I) <u>did</u> saw the deceased alive on <u>Sept. 18, 1960</u> , and that death occurred at <u>10:50AM</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>G. I. Walker, Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9-19-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. I. WALKER, JR., CAPT, MC, USN</u>				22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-21-60,</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co., 1400 Chapin St., NW, WashDC</u>				25a. REC'D BY REGISTRAR <u>SEP 21 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10511

10511



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4890 Battery Lane		d. STREET ADDRESS 4890 Battery Lane	
3. NAME OF DECEASED (Type or print) First George Middle Frank Last Royston		4. DATE OF DEATH Month Sept. Day 25 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/1896
9. AGE (In years, last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railway Express Agency		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Claude Royston		14. MOTHER'S MAIDEN NAME Blanche Popham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Frances Royston--		Address 4890 Battery Lane Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 30 minutes			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 19 58 , to Sept. 25 19 60 , that I last saw the deceased alive on Sept. 20 19 60 , and that death occurred at 10:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Benjamin Isaacson, M.D. M.D. 7733 Alaska Ave. N.W. Washington D.C. 9/25/60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Benjamin Isaacson 7733 Alaska Avenue, N.W. Wash. DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/29/60	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Culpeper, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co.		24a. REC'D BY REGISTRAR SEP 28 '60	
24b. REGISTRAR'S SIGNATURE William S. Hines			

CERTIFICATE OF DEATH

M

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF WITNESSES		16. SIGNATURE OF CORONER		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF TOWNSHIP CLERK		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF STATE CLERK		24. SIGNATURE OF U.S. CLERK		25. SIGNATURE OF VICE PRESIDENT		26. SIGNATURE OF SENATE CLERK		27. SIGNATURE OF HOUSE CLERK		28. SIGNATURE OF GOVERNOR		29. SIGNATURE OF ATTORNEY GENERAL		30. SIGNATURE OF COMPTROLLER		31. SIGNATURE OF SECRETARY OF TREASURY		32. SIGNATURE OF DEPARTMENT OF HEALTH		33. SIGNATURE OF DEPARTMENT OF EDUCATION		34. SIGNATURE OF DEPARTMENT OF AGRICULTURE		35. SIGNATURE OF DEPARTMENT OF COMMERCE		36. SIGNATURE OF DEPARTMENT OF LABOR		37. SIGNATURE OF DEPARTMENT OF MINES		38. SIGNATURE OF DEPARTMENT OF TRANSPORTATION		39. SIGNATURE OF DEPARTMENT OF PUBLIC SAFETY		40. SIGNATURE OF DEPARTMENT OF SOCIAL SERVICES		41. SIGNATURE OF DEPARTMENT OF ENVIRONMENTAL AFFAIRS		42. SIGNATURE OF DEPARTMENT OF NATURAL RESOURCES		43. SIGNATURE OF DEPARTMENT OF GENERAL SERVICES		44. SIGNATURE OF DEPARTMENT OF HUMAN RESOURCES		45. SIGNATURE OF DEPARTMENT OF INFORMATION TECHNOLOGY		46. SIGNATURE OF DEPARTMENT OF LEGAL AFFAIRS		47. SIGNATURE OF DEPARTMENT OF POLICE		48. SIGNATURE OF DEPARTMENT OF FIRE		49. SIGNATURE OF DEPARTMENT OF CORRECTIONS		50. SIGNATURE OF DEPARTMENT OF JUVENILE SERVICES		51. SIGNATURE OF DEPARTMENT OF PROBATION AND PAROLE		52. SIGNATURE OF DEPARTMENT OF MENTAL HEALTH		53. SIGNATURE OF DEPARTMENT OF SUBSTANCE ABUSE		54. SIGNATURE OF DEPARTMENT OF ADDICTION SERVICES		55. SIGNATURE OF DEPARTMENT OF COMMUNITY CARE		56. SIGNATURE OF DEPARTMENT OF ELDER SERVICES		57. SIGNATURE OF DEPARTMENT OF DEVELOPMENTAL SERVICES		58. SIGNATURE OF DEPARTMENT OF DISABILITY SERVICES		59. SIGNATURE OF DEPARTMENT OF VETERANS AFFAIRS		60. SIGNATURE OF DEPARTMENT OF MILITARY AFFAIRS		61. SIGNATURE OF DEPARTMENT OF NATIONAL GUARD		62. SIGNATURE OF DEPARTMENT OF STATE		63. SIGNATURE OF DEPARTMENT OF DEFENSE		64. SIGNATURE OF DEPARTMENT OF ENERGY		65. SIGNATURE OF DEPARTMENT OF ENVIRONMENTAL PROTECTION		66. SIGNATURE OF DEPARTMENT OF HEALTH AND HUMAN SERVICES		67. SIGNATURE OF DEPARTMENT OF EDUCATION		68. SIGNATURE OF DEPARTMENT OF AGRICULTURE		69. SIGNATURE OF DEPARTMENT OF COMMERCE		70. SIGNATURE OF DEPARTMENT OF LABOR		71. SIGNATURE OF DEPARTMENT OF MINES		72. SIGNATURE OF DEPARTMENT OF TRANSPORTATION		73. SIGNATURE OF DEPARTMENT OF PUBLIC SAFETY		74. SIGNATURE OF DEPARTMENT OF SOCIAL SERVICES		75. SIGNATURE OF DEPARTMENT OF ENVIRONMENTAL AFFAIRS		76. SIGNATURE OF DEPARTMENT OF NATURAL RESOURCES		77. SIGNATURE OF DEPARTMENT OF GENERAL SERVICES		78. SIGNATURE OF DEPARTMENT OF HUMAN RESOURCES		79. SIGNATURE OF DEPARTMENT OF INFORMATION TECHNOLOGY		80. SIGNATURE OF DEPARTMENT OF LEGAL AFFAIRS		81. SIGNATURE OF DEPARTMENT OF POLICE		82. SIGNATURE OF DEPARTMENT OF FIRE		83. SIGNATURE OF DEPARTMENT OF CORRECTIONS		84. SIGNATURE OF DEPARTMENT OF JUVENILE SERVICES		85. SIGNATURE OF DEPARTMENT OF PROBATION AND PAROLE		86. SIGNATURE OF DEPARTMENT OF MENTAL HEALTH		87. SIGNATURE OF DEPARTMENT OF SUBSTANCE ABUSE		88. SIGNATURE OF DEPARTMENT OF ADDICTION SERVICES		89. SIGNATURE OF DEPARTMENT OF COMMUNITY CARE		90. SIGNATURE OF DEPARTMENT OF ELDER SERVICES		91. SIGNATURE OF DEPARTMENT OF DEVELOPMENTAL SERVICES		92. SIGNATURE OF DEPARTMENT OF DISABILITY SERVICES		93. SIGNATURE OF DEPARTMENT OF VETERANS AFFAIRS		94. SIGNATURE OF DEPARTMENT OF MILITARY AFFAIRS		95. SIGNATURE OF DEPARTMENT OF NATIONAL GUARD		96. SIGNATURE OF DEPARTMENT OF STATE		97. SIGNATURE OF DEPARTMENT OF DEFENSE		98. SIGNATURE OF DEPARTMENT OF ENERGY		99. SIGNATURE OF DEPARTMENT OF ENVIRONMENTAL PROTECTION		100. SIGNATURE OF DEPARTMENT OF HEALTH AND HUMAN SERVICES	
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10543

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 26 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSP.				d. STREET ADDRESS Rt. 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle RUTH Last RUNYAN				4. DATE OF DEATH Month SEPTEMBER Day 12 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/12/99	
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Internal Revenue Agent		10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME LEE J. RUNYAN				14. MOTHER'S MAIDEN NAME GERTRUDE SCOTT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. none		INFORMANT HOSPITAL RECORDS, OLNEY, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INANITION DUE TO INTRAABDOMINAL CARCINOMATOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) PRIMARY ARRHENO BLASTOMA OF RIGHT OVARY							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from Aug. 58 to Sept. 12, 1964 , that I last saw the deceased alive on Sept. 12, 1960 , and that death occurred at 10:20 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/12/60							
ACTUAL SIGNATURE Jack Schumacher				M.D. _____			
PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.				_____ GAITHERSBURG, MARYLAND _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE SEP 16 '60	
24b. REGISTRAR'S SIGNATURE Charles L. House							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10344



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

10511

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 7yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 1 6-Brooks Ave	
3. NAME OF DECEASED (Type or print) First Albert Middle Nathan Last Rutledge		4. DATE OF DEATH Month Sept Day 26 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 11-1894
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Tenn,
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Connely Rutledge	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Herman Rutledge. Gaithersburg.Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19____, to 9-26 , 19 60 , that I last saw the deceased alive on 9/24 , 19 60 , and that death occurred at 2: P . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Luciano L. Ledl M.D.		ADDRESS (Street, city or town, state) Gaithersburg Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) Luciano L. Ledl			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-29-60	22c. NAME OF CEMETERY OR CREMATORY McConnells Chapel	22d. LOCATION (City, town, or county) (State) Jonesville. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR SEP 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and only sent within 72 hours after death.

VR A15 (4)
15M 9/59

10427

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10512

Item 7 Film 212-10-3-60 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
c. LENGTH OF STAY IN 1b <u>3 mo. 19 da.</u>		d. STREET ADDRESS <u>3900 14th St., N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Elizabeth Sale</u>		4. DATE OF DEATH <u>Sept. 25</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-20-11</u>
9. AGE (In years lost birthday) <u>49</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Trevor T. Hill</u>		14. MOTHER'S MAIDEN NAME <u>Mary Beale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Wash. D.C.</u>	
17. INFORMANT <u>Mrs. Mary T. Young - sister</u>		Address <u>5521 Colo. Ave., N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>161X</u> DUE TO <u>Carcinoma of Pungny + pharynx</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 7, 1960</u> to <u>Sept 25, 1960</u> , that (I) (we) lost the deceased alive on <u>Sept 23, 1960</u> , and that death occurred <u>11:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John Louzan</u>		22b. DATE SIGNED <u>Sept 26, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN LOUZAN</u>		22d. ADDRESS <u>6300 Columbia Blvd. S.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL BURIAL</u>		23b. DATE THEREOF <u>9/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>OAK HILL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>FREDERICK PURG. VA</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Erley W. Lee</u>		25a. REC'D BY REGISTRAR <u>SEP 27 '60</u>	
ADDRESS <u>1500 G. Broad St. - Alexandria</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

10127

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10544

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 275 10-17-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

10513

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLESVILLE, MD.</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARILE REST HOME</u>		d. STREET ADDRESS <u>5711-KANS. AVE. N.W. (D.C.)</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGENNA</u> Middle <u>B.</u> Last <u>SCHRAM</u>		4. DATE OF DEATH Month <u>9</u> - Day <u>29</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1865</u> <u>OCT. 11, 1865</u>
9. AGE (In years lost birthday) <u>94</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>UNK.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE STEVENS</u>		14. MOTHER'S MAIDEN NAME <u>UNK. BAXTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MARION E SCHRAM</u>		Address <u>5711 KANS. AVE D.C. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>450.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Post-operative amputation for gangrene (L) leg</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/27/1960</u> to <u>9/29/1960</u> , that I last saw the deceased alive on <u>9/28/60, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Donald Nelson</u> M.D. <u>10620 Georgia Ave. Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 1, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Joy Co. 5406 Ill. Ave. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 4 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

CERTIFICATE OF DEATH

10344

103

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Signature of physician
9. Signature of registrar
10. Date of registration



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10546

10515

FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7721 Beach Tree Rd</u>				d. STREET ADDRESS <u>17721 Beach Tree Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Fanny Holleman Semmes</u>				4. DATE OF DEATH <u>Sept 18 1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-15-1896</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stenographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Ala.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>ERASMUS JASPER Holleman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Allison</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>413-D3-5541</u>			
17. INFORMANT <u>Allison Semmes (son)</u>				Address <u>Stu 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Found dead in bed</u> (c) <u>Interval between onset and death</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>9/18/1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Chattanooga Mem. Park</u>				22d. LOCATION (City, town, or country) (State) <u>Chattanooga, Tenn</u>			
23. FUNERAL DIRECTOR <u>Joseph Laidler's Sons</u>				ADDRESS <u>1756 Pa. Ave N.W.</u>			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			
DATE <u>SEP 21 '60</u>							

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10441

CERTIFICATE OF DEATH

Reg. Dist. No. 10516

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburgh		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Pleasant Nursing Home		e. STREET ADDRESS 2100 University Blvd W	
3. NAME OF DECEASED (Type or print) First Edward Middle Benjamin Last Sewell		4. DATE OF DEATH Month Sept. Day 28 Year 1960	
5. SEX male	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1876 Sept 14, 1874
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Skilled Worker		10b. KIND OF BUSINESS OR INDUSTRY O. & P. Tel. Co.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Sewell		14. MOTHER'S MAIDEN NAME Carrie Magruder Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. cant find	
INFORMANT Elsie Sewell Horad		Address Wheaton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorenal Failure, Anuria DUE TO (b) Arteriosclerosis Renal & cerebral DUE TO (c) Nephritis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Concussion suffered 8/25/60 in fall from 2nd floor window. No fractures			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) At home. Mental confusion. Probably though cleaning windows	
20c. TIME OF INJURY Month, Day, Year 6:00 a.m. Aug. 25 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Wheaton residence; to Freedmen's Hospital, D.C.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 31 , 19 60 to Sept. 28 , 19 60 , that I last saw the deceased alive on September 27 , 19 60 , and that death occurred at 4:14 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell		ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring, Md.	
DATE SIGNED			
PHYSICIAN'S NAME (Type) Webster Sewell, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/1/60	22c. NAME OF CEMETERY OR CREMATORY Harmony Cemetery.,	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suruden		ADDRESS Rockville, Md.	24a. REC'D BY REGISTRAR OCT 4 '60
		24b. REGISTRAR'S SIGNATURE Charles L. Frank	

CENTRE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10409

10517

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WHEATON-SILVER SPRING NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
d. STREET ADDRESS 2726 Connecticut Ave., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle THEODORA Last SHANE		4. DATE OF DEATH Month SEPTEMBER Day 22 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 31, 1890
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sect'y, Veterans Adm.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Theodore Shane		14. MOTHER'S MAIDEN NAME Ella Yenney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Mrs. Harold R. Northup, 4000 Mass. Ave., N.W. Washington, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion and cachexia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cirrhosis of liver DUE TO (c) 4 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cerebral thrombosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/49 19____, to 9/22/60 19____, that (I) (we) last saw the deceased alive on 9/21/60 19____, and that death occurred at 7:30 from the causes and on the date stated above.			
22a. SIGNATURE Horace H. Custis, Jr. MD		22b. DATE SIGNED 9/22/60	
22c. PHYSICIAN'S NAME (Type) Horace H. Custis, Jr., M. D.		22d. ADDRESS 1852 Columbia Rd, N. W. Washington 9, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/24/60	
23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE SEP 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CONFIDENTIAL

10-10

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2 copies

4 copies

Administration and Logistics

Directorate of Logistics

General Information

2/22/60

2/22/60

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2/22/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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050
10547
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10518

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Greenville	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 21 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenville		d. STREET ADDRESS 101 Mount Vista Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bryan Middle Alan Last Shaw		4. DATE OF DEATH Month September Day 7 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 26, 1960
9. AGE (In years last birthday) 6 yrs.		IF UNDER 1 YEAR Months 10 Days 10 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Minor child)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bruce Shaw		14. MOTHER'S MAIDEN NAME Barbara Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 754-5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease DUE TO (c) Unknown		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 17, 1960 to September 7, 1960 , that (I) (we) last saw the deceased alive on September 7, 1960 , and that death occurred 3:50pm from the causes and on the date stated above.			
22a. SIGNATURE Nina Starr Braunwald		22b. DATE SIGNED 9-8-60	
22c. PHYSICIAN'S NAME (Type) NINA STARR BRAUNWALD, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 9-8-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Greenville, South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE SEP 13 '60	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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CERTIFICATE OF DEATH

Reg. Dist. No.

10428

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8627 Flower Avenue</u>				d. STREET ADDRESS <u>8627 Flower Avenue</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN VERNI SHEPHERD</u>				4. DATE OF DEATH Month Day Year <u>Sept. 9, 19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/2/92</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Machinest</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>							
13. FATHER'S NAME <u>William Shepherd</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Brock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>yes WW I</u>				16. SOCIAL SECURITY NO. <u>578-36-613</u>			
17. INFORMANT <u>Hilda G. Shepherd-Item# 2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatic carcinoma</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>about a yr.</u> <u>about 2 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Sept. 9,</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Sept. 8,</u> 19 <u>60</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>796 13th St., N.W., Wash., D.C.</u> DATE SIGNED <u>9/13/60</u> ACTUAL SIGNATURE <u>Walter K. Angevine</u> M.D. <u>6300-13th St., N.W., Wash., D.C.</u> PHYSICIAN'S NAME (Type) <u>Walter K. Angevine-6300-13th. St., N.W. Washington, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wynson Wheeler Funeral Home</u> <u>1331 E. Montg. Ave., Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

CHIEF

DEPT. OF HEALTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

EDUCATION

DATE OF BIRTH

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 hrs.</u>		d. STREET ADDRESS <u>12207 Ken dall ST</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harold George Shoffner</u>		4. DATE OF DEATH Month Day Year <u>9 6 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-17</u>
9. AGE (In years lost birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Representative Calif. Packing Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George Shoffner</u>		14. MOTHER'S MAIDEN NAME <u>Florence McDowell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW2 Army</u>		16. SOCIAL SECURITY NO. <u>173-01-8032</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>NONE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 HRS.</u> <u>16 HRS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>OCT 56</u> to <u>9/6</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>9/5</u> <u>1960</u> , and that death occurred on <u>9/6</u> <u>4:12 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold Sterling</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Harold Sterling</u>		22d. ADDRESS <u>1352 University Blvd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL 9/10/60</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Gulf Christian Church Cemetery, Gulf Mills, Pa.</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jisko</u>		25a. REC'D BY REGISTRAR <u>SEP 13 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		25c. ADDRESS <u>SILVER SPRING, MD.</u>	



[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the page. Some words like 'X' and 'P.O.' are visible.]

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 10430
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

10521

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>				47X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Gen-Hospital</u>				d. STREET ADDRESS <u>5121-4th St. N.E. Apt 105</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mayr</u> Middle _____ Last <u>SHUKIN</u>				4. DATE OF DEATH Month <u>9</u> Day <u>12</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Jewish</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-82</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>fruit merchant (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Morris SHUKIN</u>				14. MOTHER'S MAIDEN NAME <u>Ethel (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Son & old Record</u>				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>He knows</u> DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH _____
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>9/7/1960</u> to <u>9/12/1960</u> that (I) (we) last saw the deceased alive on <u>Sept 12, 1960</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas H Wolohin</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>				22d. ADDRESS <u>300 Woodward Park</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9/13/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETH SHOLOM CEM</u>		23d. LOCATION (City, town, or county) <u>DC.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Boeking Funeral Home</u>				ADDRESS <u>4217-9th Ave</u>		25a. REC'D BY REGISTRAR <u>DATE SEP 14 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

10521

OFFICE OF THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT

10430

104

104



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10548

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 FilmG272 10-3-60 et
CERTIFICATE OF DEATH

10522

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN TB 16 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander home of Rest		d. STREET ADDRESS 2032 Belmont Road, NW	
3. NAME OF DECEASED (Type or print) First Harriet Middle V Last Smoot		4. DATE OF DEATH Month Sept Day 24 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26-1901
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months 1 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher-Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Springville. N.Y.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Vedder		14. MOTHER'S MAIDEN NAME Altha Rust	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
INFORMANT Records-The Marylander home of Rest		Address # As 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 10 minutes 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 16, 1957 to September 24, 1960 that I last saw the deceased alive on September 22, 1960 and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James R. Kerr		ADDRESS (Street, city or town, state) Bladensburg, Md.	
PHYSICIAN'S NAME (Type) 		DATE SIGNED 9/24/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 9-27-60	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Emmett G. Hartman		24a. REC'D BY REGISTRAR SEP 28 '60	
ADDRESS Faithsburg 91st		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

(M)

10544

CENTRAL OF DEATH

Management to

Department of Health

The Department of Health

Office of the Secretary

July 24-1961

Washington, D.C.

Dear Sir:

Enclosed for the Washington

Department of Health

is a copy of the

report of the

Committee on

the

Department of Health

and the

Department of Health

is a copy of the

report of the

10549

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10523

Items 3, 10a, 14 Film 6271 9-23-60 et

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form-P43. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT. (M)

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5011 Greenway Dr</u>		d. STREET ADDRESS <u>15011 Greenway Dr</u>	
3. NAME OF DECEASED (Type or print) <u>William Soaper Stanley</u>		4. DATE OF DEATH <u>Sept 7 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1908</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.S.S.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Ky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>A. O. Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Sue Bluffman Soaper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Louise T. Stanley (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bullet wound thru skull</u>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Self-inflicted bullet wound thru skull</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>2:00 a.m. 9-7 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Bethesda Montg md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation 9/8/60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(14)

(15)

RECEIVED
JAN 11 1900
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

Robert A. Pughney, Bethesda, Maryland, Jan 11 1900
Cedar Hill Observatory, Swanton, Maryland

Frank J. Bissell, Jan 11 1900

Jan 11 1900
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

Jan 11 1900
U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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U.S. DEPT. OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
JAN 11 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10550

CERTIFICATE OF DEATH

10524

Items 1, 2, 13, 14 File 6272-10-5-60 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 48 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4826 4827 Montgomery Lane		d. STREET ADDRESS 4826 4827 Montgomery Lane	
3. NAME OF DECEASED (Type or print) First Lucille Middle H Last Steed		4. DATE OF DEATH Month Sept. Day 27 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 9 Days 11 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME E. V. Hendrix		14. MOTHER'S MAIDEN NAME Lulla W. Willimon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Leon S. Steed, -Husband-same 2d		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CHRONIC PYELONEPHRITIS DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RHEUMATOID ARTHRITIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT. 1, 1958 to SEPT. 27, 1960 , that (I) was last saw the deceased alive on 9/27/1960 , and that death occurred at 2:34 PM , from the causes and on the date stated above.			
22a. SIGNATURE John H. Tuohy		22b. DATE SIGNED 9/27/60	
22c. PHYSICIAN'S NAME (Type) John H. Tuohy, M.D.		22d. ADDRESS 7720 Wisc. Ave. Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/29/60	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR SEP 29 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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John H. P. 1874

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10525

10551

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 22 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 250 Farragut St., N.W.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Morris Middle (n) Last STEELE				4. DATE OF DEATH Month September Day 2 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-14-96	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps			
11. BIRTHPLACE (State or foreign country) New Jersey				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME George Steele				14. MOTHER'S MAIDEN NAME Frances ROBINSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WWI & WWII		17. INFORMANT Mrs. Ella STEELE		Address Same as 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 451X IMMEDIATE CAUSE (a) Coronary artery thrombosis during surgery for abdominal aortic aneurysm DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 years 10 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 60				20g. (County) 60		20h. (State) 60	
21. I certify that (I) (this hospital) attended the deceased from 8-11-1960 to 9-2-1960 , that (I) (we) last saw the deceased alive on 9-2-1960 , and that death occurred at 12:30 PM from the causes and on the date stated above.							
22a. SIGNATURE J. E. MC CLENATHAN				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-2-60	
22c. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9-7-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town, or county) Arlington, Virginia				23e. (State) Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME, 4812 Georgia Ave., N.W., Wash. D.C.				25a. REC'D BY REGISTRAR SEP 7 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1955

Place of Death

Residence

Age

Sex

Occupation

Marital Status

Signature

Date

Place

Signature

Date

Place

Signature

Place

Signature

Date

Place

1-2-55

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10552

10526

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b Washington d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5007 Fort Sumner Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Belle STONER		4. DATE OF DEATH Month Day Year September 26 19 60	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-14-79
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William BAILEY		14. MOTHER'S MAIDEN NAME Mialma DULL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (D) Mrs. Paul W. Russell, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) personnel attended the deceased from Sept. 25 1960 to Sept. 26 1960 , that (I) personnel saw the deceased alive on Sept. 26 1960 , and that death occurred at 2:25 AM , from the causes and on the date stated above.			
22a. SIGNATURE John Wood Davis		22b. DATE SIGNED 9-26-60	
22c. PHYSICIAN'S NAME (Type) John Wood DAVIS, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Shipment 9-26-60		23b. DATE THEREOF 9-26-60	
23c. NAME OF CEMETERY OR CREMATORY Scottdale Cemetery		23d. LOCATION (City, town, or county) (State) Scottdale Penn.	
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		25a. REC'D BY REGISTRAR DATE SEP 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

10535

CERTIFICATE OF DEATH

Name of Deceased		John Wood Davis, Jr.	
Date of Death		April 25, 1950	
Place of Death		U. S. Naval Hospital, Bethesda, Md.	
Age		34	
Sex		Male	
Race		White	
Marital Status		Married	
Cause of Death		Myocardial Infarction	
Disease or Injury		Coronary Artery Disease	
Occupation		Lieutenant Junior Grade, U. S. Navy	
Residence		Bethesda, Md.	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		April 25, 1950	
Place of Registration		Bethesda, Md.	

CERTIFICATE OF DEATH

Reg. Dist. No.

10527

10553

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST FRIENDSHIP	
c. LENGTH OF STAY IN 1b 6 DAYS		d. STREET ADDRESS 17 SOUTH IVORY ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NETTIE Middle ELIZABETH Last SULLIVAN		4. DATE OF DEATH Month SEPTEMBER Day 10 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-1880
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JOHN WILLIAM MUSGROVE	
14. MOTHER'S MAIDEN NAME LOUISE GRIMES		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. None		INFORMANT HOSPITAL RECORDS OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Nephrosclerosis & uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 8, 1947 to Sept 10, 1960 that I last saw the deceased alive on Sept. 10, 1960 and that death occurred at 12:00 pm from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles S. Whitaker, M.D.			
PHYSICIAN'S NAME (Type) C. S. WHITAKER M. D., CLARKSVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-13-60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel	22d. LOCATION (City, town, or county) (State) Sunshine, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE SEP 14 '60	24b. REGISTRAR'S SIGNATURE Charles S. Whitaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10533

RECEIVED

RECEIVED

RECEIVED

WEST VIRGINIA

5 DAYS

5 DAYS

WEST VIRGINIA

HOSPITAL GENERAL HOSPITAL

WEST VIRGINIA

ELIZABETH HILLMAN

WHITE

WEST VIRGINIA

WHITE

WEST VIRGINIA

WHITE

WHITE

WEST VIRGINIA

WHITE

WEST VIRGINIA

HOSPITAL RECORDS

WHITE

WHITE

General Hospital

General Hospital

General Hospital

7-10-50

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

WEST VIRGINIA

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10554 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westmore		c. LENGTH OF STAY IN 1b 2 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A.J. Ellis Construction Co.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Earl Last Teague		4. DATE OF DEATH Month Sept Day 7 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/30
9. AGE (In years last birthday) 30 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George B. Teague		14. MOTHER'S MAIDEN NAME Catherine Ammons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 245-40-4470	
17. INFORMANT George B. Teague, Jr. Brother		Address 1215 1/2 St. Frederick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Transection cervical spinal cord DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture dislocation cervical vertebrae DUE TO (c) Crushing trauma (Falling heavy drane)		INTERVAL BETWEEN ONSET AND DEATH immediate sudden sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dismantling a large crane when it fell on him			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dismantling a large crane when it fell on him	
20c. TIME OF INJURY Month, Day, Year 9/7/60		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Westmore		20f. (City or town) (County) (State) Westmore Montgomery Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Brodchart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Brodchart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept. 9, 1960	
22c. NAME OF CEMETERY OR CREMATORY Boone,		22d. LOCATION (City, town, or county) (State) North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Fredetick, Maryland		24a. REC'D BY REGISTRAR SEP 13 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

074

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15

2

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10555 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10529

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 45 Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6314 Bells Mill Rd. Suburban Hosp.		d. STREET ADDRESS 6314 Bells Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Omie L. Terry		4. DATE OF DEATH Month Day Year Sept. 19, 1960 19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/12/11		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 10 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Georgetown Hospital		11. BIRTHPLACE (State or foreign country) Ga.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Walter C. Heath		14. MOTHER'S MAIDEN NAME Izza W. Flowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW 2 579-09-0926		17. INFORMANT Mr. John Terry, step-son Address 10110 Summit Ave., Kensington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of Gastric Contents (c) Compromise of Spinal Cord PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, Rt. Femur.		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden 29 hours		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which struck tree			
20c. TIME OF INJURY Month, Day, Year Hour Min. 9/18/60 5:48 P.M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street	
20f. (City or town) Bethesda		20g. (County) Montg.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/20/60	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-23-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.	
22d. LOCATION (City, town, or county) Arlington, Virginia		22e. REC'D BY REGISTRAR DATE SEP 23 '60		22f. REGISTRAR'S SIGNATURE Arthur S. Kline	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.					

FOR STATE
HEALTH DEPT.

(M)

1

PROMISE

THIS IS TO CERTIFY THAT THE ABOVE NAMED DECEASED PERSON WAS
FOUND DEAD AT THE PLACE AND TIME AND IN THE MANNER
AND BY THE NAME OF THE EXAMINER AND THE CAUSE OF DEATH
AS STATED HEREON.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10556
10530
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>D. C.</u> <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Sanitarium</u>		d. STREET ADDRESS <u>5011 Lowell St N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR H. TEW</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business man.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stationery</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JCW</u>		14. MOTHER'S MAIDEN NAME <u>Buchanan.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-07-1038</u>	
17. INFORMANT <u>MRS. H. Wheeler</u>		Address <u>5011 Lowell St. N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic arterio sclerotic heart disease</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Semility</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Chronic.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1</u> 19 <u>60</u> to <u>Sept 26</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>Sept 24</u> 19 <u>60</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>E. H. Nicholas</u>		22b. DATE SIGNED <u>9/26/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. H. Nicholas</u>		22d. ADDRESS <u>4830 - V St. N.W. Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/28/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 27 '60</u>	
Address <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>	
<u>7557 Wisconsin Dr Bethesda, Md</u>			

M

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CHIEF

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10531

10557

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 296 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				d. STREET ADDRESS 437 Kennedy Street, NW, Apt. 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Theodore Last Thompson, Sr.				4. DATE OF DEATH Month September Day 24 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 4, 1910	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.	IF UNDER 24 HRS. Months 50 Days 50 Hours 50 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Dealer in Meat		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Will Thompson				14. MOTHER'S MAIDEN NAME Hattie Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1928 - 1931 577-09-9133		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Standstill 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia, Bacteremia, Inanition DUE TO (c) Extensive Metastatic Carcinoma of Rectum							INTERVAL BETWEEN ONSET AND DEATH 19 days 39 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from December 3, 1959 to Sept. 24, 1960 that (I) (we) last saw the deceased alive on Sept. 24, 1960 and that death occurred 12:15 pm from the causes and on the date stated above.							
22a. SIGNATURE George F. Miller, Jr.				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-25-60	
22c. PHYSICIAN'S NAME (Type) GEORGE F. MILLER, JR., M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/28/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE W W Chambers Co.				ADDRESS 3072 - M St N.W. Wash, D.C.		25a. REC'D BY REGISTRAR SEP 28 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

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10558

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10532

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY D. D.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 100 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 147 Prince George Street			
3. NAME OF DECEASED (Type or print) First Ladeama Middle Beatrice Last THOMPSON				4. DATE OF DEATH Month September Day 4 Year 19 60			
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-29-99	9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Gifford				14. MOTHER'S MAIDEN NAME Bertha Spencer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic CA DUE TO intracranial 1953-60 (c) Adeno Carcinoma of the breast 7 years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-27-60 to 9-4 19 60 , that (I) (we) last saw the deceased alive on 9-4 19 60 , and that death occurred at 3:55 PM from the causes and on the date stated above.							
22a. SIGNATURE John E. Knowles, M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 9 6 60	
22c. PHYSICIAN'S NAME (Type) John E. KNOWLES, LT, MC, USN				22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9 8 60		23c. NAME OF CEMETERY OR CREMATORY U.S. National		23d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons, Annapolis, Md.				25a. REC'D BY REGISTRAR SEP 9 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

1865

1865

1865

1865

VS. A15ME
5M 7/59

1. PLACE OF DEATH e. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, If institution had residence before admission) a. STATE Maryland		b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Seneca		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac River		d. STREET ADDRESS 1955 Seminary Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Jacob Turner Jr.		4. DATE OF DEATH Sept 17, 1960		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/15/1914	
10a. USUAL OCCUPATION (Give kind of work done during last 12 months, even if retired) Printer (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY		9. AGE (In years last birthday) 45 yrs.	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME John J. Turner, SR.		14. MOTHER'S MAIDEN NAME Helen Eva Duley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW # 2	
16. SOCIAL SECURITY NO. none		17. INFORMANT Edward F. Gummel		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Asphyxia 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Drowning (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Drowned while boating on Pot. River nears Seneca, Md.		INTERVAL BETWEEN ONSET AND DEATH sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Drowned while boating on Pot. River nears Seneca, Md.		20c. TIME OF INJURY Hour, min. 9/17/60	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac R. nr Seneca Montg. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/24/60	
ACTUAL SIGNATURE Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		Address (Street, city, town, or county) SILVER SPRING, MD.		(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/28/60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY	
22d. LOCATION (City, town, or country) ARLINGTON, VIRGINIA		23. FUNERAL DIRECTOR WARNER E. PIMPHREY, INC.		24a. REC'D BY REGISTRAR SEP 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS SILVER SPRING, MD.		24d. DATE SEP 29 '60	

RECEIVED

10580



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10453

10535

1. PLACE OF DEATH COUNTY <u>Montgomery</u> <u>Kensington Gardens San.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2019 Eye Street, N. W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		d. STREET ADDRESS <u>47X</u>	
3. NAME OF DECEASED (Type or print) First <u>Olive</u> Middle <u>Van</u> Last <u>Wagenen</u>		4. DATE OF DEATH Month <u>9</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 30, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>14</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service Comm.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Y. State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John Van Wagenen</u>		14. MOTHER'S MAIDEN NAME <u>Jane E. Van Acken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>S. C. LAKE</u>		Address <u>189 Highland Ave, Nutley, N. J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Inadequate Intake</u> (c) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 19 <u>60</u> , to <u>Sept 9</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sept 9</u> 19 <u>60</u> , and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Leonard Gold</u>		22b. DATE SIGNED <u>9/14/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Leonard Gold, M. D.</u>		22d. ADDRESS <u>8641 Coltsville Road, Silver Sp., Md.</u>	
23a. BURIAL, CREMATION, or TRANSIT <u>Burial</u>		23b. DATE THEREOF <u>9/12/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Poughkeepsie Rural Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Poughkeepsie New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Murphy Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 14 '60</u>	
ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

STATE OF TEXAS

10438

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10454
CERTIFICATE OF DEATH

10537

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDEN SAN.</u>		d. STREET ADDRESS <u>618 - WEST NORTH AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>Alice Blanche Watchman</u>		4. DATE OF DEATH <u>SEPT 10 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 17 - 1884</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR: Months <u>86</u> Days <u>86</u> Hours <u>86</u> Min. <u>86</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sales Lady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Concunatus Jelks</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>E.g. Duncan 7206-401122-2nd</u>	
17. INFORMANT <u>E.g. Duncan 7206-401122-2nd</u>		Address <u>distinct Heights</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure, acute</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Dehydration</u> (c) <u>Chronic Dehydration</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1958 to Sep 9</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Sep 9</u> 19 <u>60</u> , and that death occurred at <u>9:50 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u> M.D.		22b. DATE SIGNED <u>Sep 10/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		22d. ADDRESS <u>10609 CONCORD AVE KENSINGTON MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept 13-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>SIMMONS BROS.</u>		25. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
ADDRESS <u>1661 9th St. N.E. D.C.</u>		DATE <u>SEP 13 '60</u>	

(M)

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29 10/20

Simmons Bros
1041 1/2
1042

CERTIFICATE OF DEATH

Reg. Dist. No.

10561

10538

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. General Hospital				e. STREET ADDRESS Box 171			
3. NAME OF DECEASED (Type or print) First OLIVE Middle MYERS Last WATERS				4. DATE OF DEATH Month SEPT. Day 14 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/99		9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME KIRK GRIFFITH				14. MOTHER'S MAIDEN NAME MINNIE RIGGS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT HOSPITAL RECORDS,		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Valvulitis, Chronic, due 411X DUE TO Rheumatic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Not Known.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950 , to Sept. 14, 1960 , that I last saw the deceased alive on Sept. 13, 1960 , and that death occurred at 5:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) GAITHERSBURG, MARYLAND DATE SIGNED 9/14/60							
ACTUAL SIGNATURE Jack Schumacher M.D.				DATE SIGNED 9/14/60			
PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.				GAITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-17-60		22c. NAME OF CEMETERY OR CREMATORY Neelsville		22d. LOCATION (City, town, or county) (State) Germantown, RED, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.				24a. RECEIVED BY REGISTRAR SEP 16 60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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CERTIFICATE OF DEATH

10001

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

EDUCATION

30

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

EDUCATION

DATE OF DEATH

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CAUSE OF DEATH

DATE OF BIRTH

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EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

CERTIFICATE OF DEATH

Reg. Dist. No.

10539

10562

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>				c. LENGTH OF STAY IN 1b <u>11/24/59-9/3/60</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FAIRLAND NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>WATSON</u> Last <u>WATSON</u>				4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/27/1873</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>6</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INTERIOR DECORATOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Decorating</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							
13. FATHER'S NAME <u>David Watson</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Patrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>202-05-6643</u>			
17. INFORMANT <u>Niece</u>				Address <u>Wash. 16, D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> DUE TO <u>210 X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Nov 24</u> , 19 <u>59</u> , to <u>Sept. 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 31</u> , 19 <u>60</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1019 University Boulevard</u> DATE SIGNED <u>9/3/60</u>							
ACTUAL SIGNATURE <u>Boris Rabkin</u>				M.D. <u>Silver Spring Maryland</u>			
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/8/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bordentown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bordentown, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND MONTGOMERY

BETHEDA, MARYLAND

2002 BALHONTER RD

Robert A. Bingham, Jr.

Born 1910

Forrest, Georgia

Forrest, Georgia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/59

10411

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10540

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>1 YEAR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, MARYLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>JOHNSON'S NURSING HOME</u>				d. STREET ADDRESS <u>8415 NEW HAMPSHIRE AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>JOHN</u> Last <u>WEBER</u>				4. DATE OF DEATH Month <u>SEPT.</u> Day <u>30</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 20, 1875</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINER (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MINING (coal)</u>		11. BIRTHPLACE (State or foreign country) <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WM. WEBER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS. BEULAH MC HOCKO 8415 NEW HAMPSHIRE HYATTSVILLE, MD AVE.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE BRONCHIAL ASTHMA</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY EMPHYSEMA</u> DUE TO (c) <u>PULMONARY FIBROSIS</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 HRS.</u> <u>7 YRS.</u> <u>10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>GENERAL AND CEREBRAL ATHEROSCLEROSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 11, 1956</u> to <u>Sept. 30, 1960</u> , that (I) (we) last saw the deceased alive on <u>Sept. 30, 1960</u> and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. Roberts</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/30/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				22d. ADDRESS <u>8907 Georgia Ave. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. & BURIAL</u>		23b. DATE THEREOF <u>10/3/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hollisterville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hollisterville, Lackawanna Co. Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WANNER E. PUMPHREY, INC. Raymond A. Jura</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 3 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and within 72 hours after death.

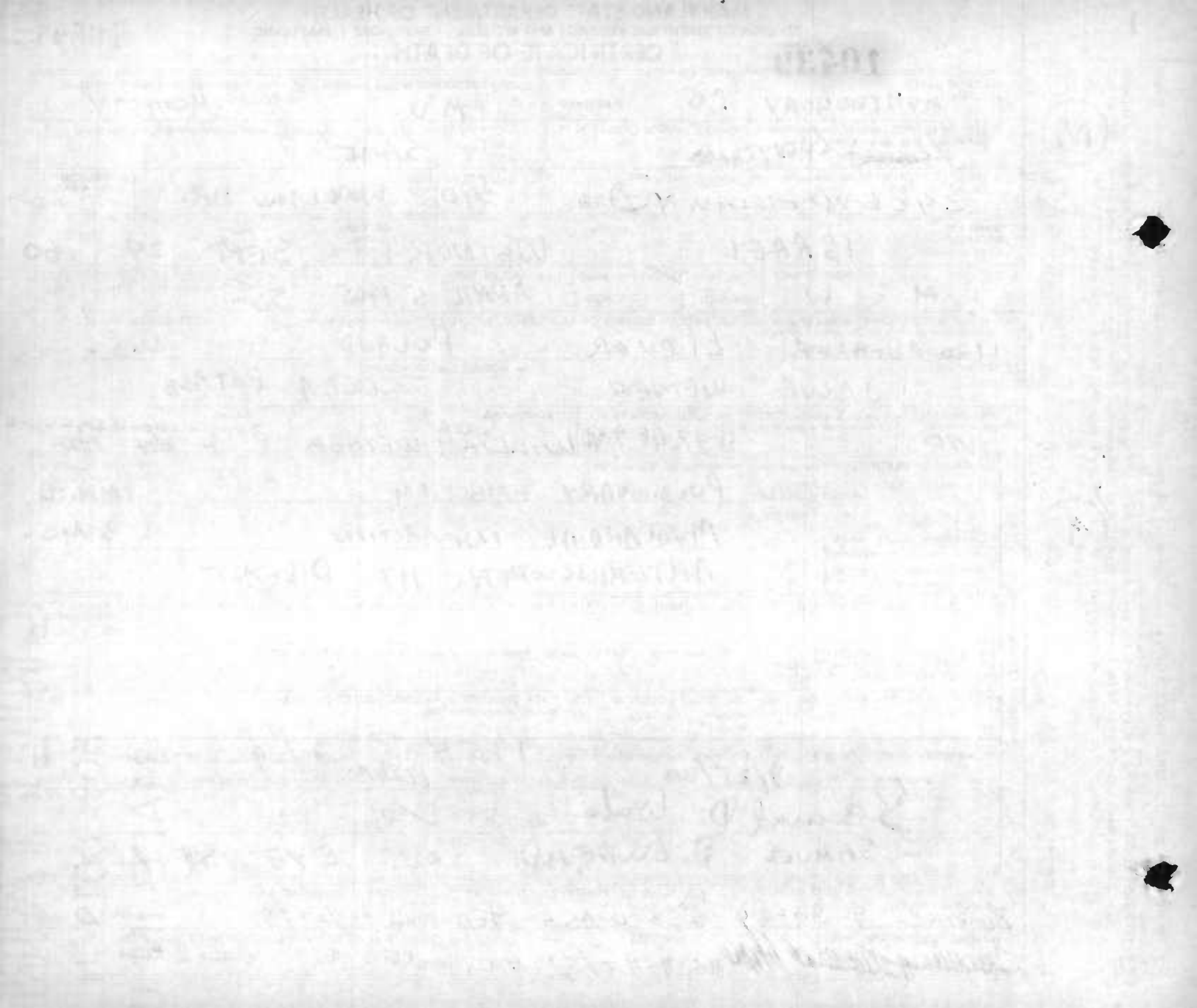
VR A15 (4)
15M 9/59

1
10439

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10541

1. PLACE OF DEATH a. COUNTY MONTGOMERY CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENNETT CHERYCHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 SAME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3906 WOODLAWN DR.		d. STREET ADDRESS 1 3906 WOODLAWN DR.	
3. NAME OF DECEASED (Type or print) First ISRAEL Middle WEINER Last WEINER		4. DATE OF DEATH Month SEPT. Day 29 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5, 1905
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 55 Hours 55 Min. 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIQUOR DEALER		10b. KIND OF BUSINESS OR INDUSTRY LIQUOR	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JACOB WEINER		14. MOTHER'S MAIDEN NAME ZELDA POTASH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-48-9246	
17. INFORMANT SON Address 3906 WOODLAWN DR. CH. CH. MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MYOCARDIAL INFARCTION DUE TO (c) ARTERIOSCLEROTIC HT. DISEASE INTERVAL BETWEEN ONSET AND DEATH IMMED. 3 MO.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1954 to 9/29 19 60 that (I) (we) last saw the deceased alive on 9/25/60 , and that death occurred at 12:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Samuel D. Weber M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) SAMUEL D. LOUBE, M.D.		22d. ADDRESS 2025 EYE ST. N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-30-60	
23c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEMORIAL HILLS		23d. LOCATION (City, town, or county) (State) MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Georgy H. H. H. ADDRESS 4217-92 ST. N.W.		25a. REC'D BY REGISTRAR OCT 3 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. H.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10563
CERTIFICATE OF DEATH
10542

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 33 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center		d. STREET ADDRESS (No street address)	
3. NAME OF DECEASED (Type or print) First Deborah Middle Carolyn Last White		4. DATE OF DEATH Month September Day 28 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1951
9. AGE (In years lost birthday) 9 yrs.		10. IF UNDER 1 YEAR Months 9 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William White		14. MOTHER'S MAIDEN NAME Estelle Cartin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Staphylococcal septicemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphatic Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 days 1 year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from August 26, 1960 to September 28, 1960 , that (I) (we) last saw the deceased alive on Sept. 28, 1960 , and that death occurred 10:15 AM from the causes and on the date stated above.			
22a. SIGNATURE <i>W. Walter Oppelt</i>		22b. DATE SIGNED 9/28/60	
22c. PHYSICIAN'S NAME (Type) W. Walter Oppelt, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/29/60	
23c. NAME OF CEMETERY OR CREMATORY Highland Mem Gardens		23d. LOCATION (City, town, or county) (State) Logan West Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co-2901-14th St NW DC		25a. REC'D BY REGISTRAR SEP 30 '60	
25b. REGISTRAR'S SIGNATURE <i>Clifford S. Hines</i>			



1050

CERTIFICATE OF DEATH

30 days

The undersigned

Deputy

Registrar

do hereby

certify that

John

the deceased, was born in

County of ... State of ...

and died on the ... day of ...



Witness my hand

at ...

this ... day of ...

19...

England and Wales

London West Virginia

The ... of ...

CERTIFICATE OF DEATH

Reg. Dist. No.

10543

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>14 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp</u>		d. STREET ADDRESS <u>8401-16th St.</u>	
3. NAME OF DECEASED (Type or print) <u>Gertrude Mae Williams</u>		4. DATE OF DEATH <u>September 16</u> 19 <u>60</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 7, 1901</u>
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
12. CITIZEN OF WHAT COUNTRY? <u>American</u>		13. FATHER'S NAME <u>Charles J. Seip</u>	
14. MOTHER'S MAIDEN NAME <u>Grace Sickler</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Washington San & Hosp. Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with Metastases</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July</u> , 19 <u>58</u> , to <u>Sept 16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Sept 15</u> , 19 <u>60</u> , and that death occurred at <u>1:25 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock, M.D.</u>		ADDRESS (Street, city or town, state) <u>7717 Carroll Ave</u> DATE SIGNED <u>9-16-60</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock, M. D.</u>		<u>Takoma Park 12 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT & BURIAL</u>	22b. DATE THEREOF <u>9/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Valley View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lackawanna County, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>SEP 19 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10544

10564

Item 7 Film 62/1 9-20-60 et

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Derwood R.F.D.#1 c. LENGTH OF STAY IN 1b Derwood R.F.D.#1 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ammons Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, d. STREET ADDRESS River Road., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Wilmore Last Wilmore		4. DATE OF DEATH Month Sept Day 8 Year 19 60	
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 8 Days 19 Hours 60 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Laborer	
11c. BIRTHPLACE (State or foreign country) Eastern Shore, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Nursing Home Records	
17. INFORMANT Nursing Home Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure. DUE TO 422-2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 1960 to 9/8 1960 that (I) (we) last saw the deceased alive on Sept 7 1960 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Luciano L. Leal		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Luciano L. Leal M.D.		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/60	
23c. NAME OF CEMETERY OR CREMATORY County Home		23d. LOCATION (City, town, or county) (State) Rockville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swander		25a. REC'D BY REGISTRAR SEP 13 '60	
25b. REGISTRAR'S SIGNATURE Robert L. Swander		25c. ADDRESS	

CERTIFICATE OF DEATH

10554

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Date of burial

8. Place of burial

9. Signature

10. Signature

CHIEF OF BUREAU

10554

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10458

10545

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE see below b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. Kenesaw Apts.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chestnut Lodge, Inc.				d. STREET ADDRESS 16th and Irving St., N.W.			
3. NAME OF DECEASED (Type or print) First Flora Middle Street Last Wilson				4. DATE OF DEATH Month September Day 10 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/15/80	
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife-teacher				10b. KIND OF BUSINESS OR INDUSTRY none(school)		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Daniel Baier Street				14. MOTHER'S MAIDEN NAME Susan Emily Gullett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Address Chestnut Lodge, Inc. Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, right upper lobe, lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162X DUE TO (c) 2mc.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic peptic ulceration, first portion of duodenum + hemorrhage							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville, Md.				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 1955 to 9-10 19 60 , that (I) (we) last saw the deceased alive on 9-9 19 60 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Corinne Cooper				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Corinne Cooper				22d. ADDRESS Rockville, Md. 104 S. Washington St.,			
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> Burial		23b. DATE THEREOF 9/12/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE SH. Hines Co				ADDRESS 2901-14th St. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR SEP 13 '60	
				25b. REGISTRAR'S SIGNATURE Carlton L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10565

10546

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>14528 Fairfield Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Newton</u> Middle <u>Ordis</u> Last <u>Wing</u>				4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/18/84</u>	
9. AGE (In years lost birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>10</u> Min. <u>00</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Monson, Mass</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Albert Wing</u>				14. MOTHER'S MAIDEN NAME <u>Abigail Newton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>333-33-10</u>		17. INFORMANT <u>Sam Roger Wing</u> Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Cirrhosis</u> DUE TO <u>581.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1943</u> to <u>9-25</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>9-25</u> 19 <u>60</u> and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul D. Cantor</u>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>Paul D. Cantor</u>				22d. ADDRESS <u>1709 Montgomery La. Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 28, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) <u>Bladensburg Rd., Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chry Chas Funeral Home</u>				ADDRESS <u>Wash. D.C. 5103 Wisconsin Ave.</u>		25a. REC'D BY REGISTRAR <u>SEP 29 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Carlton L. Harris</u>							

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MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1981

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CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
10566
CERTIFICATE OF DEATH

10547

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>7 days</u>		d. STREET ADDRESS <u>14105 Canterbury Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Page Robt Wotring</u>		4. DATE OF DEATH Month Day Year <u>Sept 5 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1892</u>
9. AGE (In years lost birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>storekeeper self employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West. Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Wotring</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Shuttleworth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>232-38-6114</u>	
17. INFORMANT <u>Agnes Wotring / same as above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 584X DUE TO (b) <u>Thrombosis, Hepatic + Portal Veins</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Obstruction, common Bile duct by calculi with cholangitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 30</u> 19 <u>60</u> , to <u>Sept 5</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>9-5</u> 19 <u>60</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>J.P. McCarrick</u> M.D.		22b. DATE SIGNED <u>9-5-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>J.P. McCARRICK M.D.</u>		22d. ADDRESS <u>809 Vicks Mill Rd. Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/8/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Terra Alta, W. Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>SEP 9 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

10000

CERTIFICATE OF DEATH

Robert
Terra Alta Cemetery
Terra Alta, Maryland

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10567
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10548

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4115 Tulare Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Louis Last Yazge				4. DATE OF DEATH Month September Day 15 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1960		9. AGE (In years last birthday) yrs. 5 IF UNDER 1 YEAR Months 8 Days 8 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Raymond Yazge				14. MOTHER'S M maiden name M. Miriam Bashoor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Escherichiacoli septicemia DUE TO (c) Staphylococcal Enterocolitis							INTERVAL BETWEEN ONSET AND DEATH 2 days 3 days 5-6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diffuse hepatic tumor							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (M) (this hospital) attended the deceased from September 1, 1960 to September 15, 1960 that (M) (we) lost saw the deceased alive on September 15, 1960 , and that death occurred on September 15, 1960 from the causes and on the date stated above.							
22a. SIGNATURE Orlando Wesley McBride				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. 9/15/60		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Orlando Wesley McBride, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/17/60		23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE SEP 19 1960	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

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SECRET

UNITED STATES OF AMERICA

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[Faint, mostly illegible text covering the majority of the page, appearing to be a document or report.]

